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**INFLUENCING TRENDS IN BREASTFEEDING; A CRITICAL  
EXAMINATION OF CONTEMPORARY APPROACHES TO HEALTH  
PROMOTION.**

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## **Abstract**

The aim of this dissertation is to examine critically whether contemporary approaches to health promotion have the potential to influence trends in breastfeeding. A selection of data relating to the practice of breastfeeding and current health promotion activity, in conjunction with a literature review forms the basis for this analysis. A comprehensive understanding of the activity of breastfeeding is achieved by analysing the scientific evidence relating to breastfeeding, identifying the patterns of breastfeeding and determining the factors that affect the activity. This analysis provides the basis for further investigation. Using the WHO/Ottawa Charter (1986) framework of health promotion both the current concept of health promotion, and current health promotion activity are examined in relation to the practice of breastfeeding

The analysis reveals that, paradoxically, fewer women are breastfeeding at a time when scientific evidence is increasingly supportive of breastfeeding. Social factors (such as work and family support), the availability of infant formula and inadequate health professional support have all affected breastfeeding trends. The issue of empowerment as the 'key principle' of all health promotion activity has important implications for the health promoter in that it requires him/her to work in a fundamentally different way. Examining the proposed strategies in the Ottawa Charter (1986) demonstrates that he/she needs different skills, while the implications that empowering strategies would not necessarily increase the number of women who breastfeed, when targets have been set to increase their number to 75%, provide an additional complication. The incongruity of the WHO linking targets to the Ottawa Charter (1986) when empowerment itself is not the measured goal, is identified as potentially damaging for health promotion in practice.

In practice at both national and local level, although the current rhetoric of health promotion is used, there is little evidence that practice is empowering in its effect. As anticipated, the use of target setting appears to encourage a coercive as opposed to empowering approach with health professionals adhering more towards a traditional educational model of health promotion. At national level the 'unwillingness' of government and the infant food manufacturers to create a more supportive environment for breastfeeding demonstrates their lack of commitment to the principle of empowerment, with evidence suggesting they would both contest the validity of the concept.

At local level, one study identifies health promotion that is empowering. This demonstrates that breastfeeding trends can be influenced (4% increase in 3years-Study in Hillingdon 1995). Nevertheless without a more supportive environment, by providing longer maternity leave and work placed nurseries, for example, it appears unlikely there will be a significant change in the trends. The need to measure health promotion activity through empowerment rather than the number of women who breastfeed could provide a more accurate assessment of health promotion activity, encouraging the health promoter to adopt more empowering strategies. Target setting, if it is necessary, needs to reflect empowerment with the trends in breastfeeding monitored. This would achieve a more comprehensive understanding of trends in breastfeeding and the influence of health promotion.

**'The Work is original and has not been submitted  
previously in support of any degree qualification  
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**List of abbreviations.**

|        |  |
|--------|--|
| COMA   | Committee on Medical Aspects of Food Policy                |
| DHSS   | Department of Health and Social Security                   |
| DoH    | Department of Health                                       |
| GP     | General Practitioner                                       |
| HVA    | Health Visitors Association.                               |
| IBFAN  | International Baby Food Action Network                     |
| NCT    | National Childbirth Trust                                  |
| NHS    | National Health Service.                                   |
| RCM    | Royal College of Midwives                                  |
| UNICEF | United Nations International<br>Children's Emergency Fund. |
| WHO    | World Health Organisation                                  |

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## **Introduction.**

'Breastfeeding is an integral part of the reproductive process, the natural and ideal way of feeding the infant and a unique biological and emotional basis for child development. This together with its other important effects, on the prevention of infection, the health and well-being of the mother, on child spacing, on family health, on family and national economies and on food production, makes it a key aspect of self reliance, primary health care and current developmental approaches.' (WHO/UNICEF 1979 cited in Hytten 1991).

The above claim by the WHO demonstrates a long standing belief by the medical profession that 'breastfeeding is the best feeding.' In 1974 the COMA Report, 'Present day practice in infant feeding', recommended that all women should breastfeed for a minimum of 4 months. In the intervening years this was lowered tentatively to 3 months (COMA 1988 cited by Inch 1995), but the most recent COMA Report (1994) has retracted this statement considering that 'closure' of the gut epithelium to large antigens such as foreign protein molecules only occurs between 3-4 months (Walker 1994 cited in Inch 1995) and, that being the case, four months is the earliest 'foreign substances' should be introduced. To this end, midwives, health visitors and other medical personnel are expected to promote breastfeeding as the best food for babies. Literature is provided by the Health Education Authority to advise women about the benefits of breastfeeding and health promotion campaigns are held every May, when professionals and voluntary agencies such as the National Childbirth Trust promote the cause of breastfeeding. In their commitment to supporting those who breastfeed, the NCT, in some instances, appears to operate a service that mirrors that of the health professional, by providing the support of 500 breastfeeding counsellors and access to breastfeeding equipment such as breast pumps (Kitzinger 1990).

However, despite the recommendations and extensive health promotion activity over the past 22 years many women do not breastfeed. In 1989, Smith and Jacobsen, in the



report 'The Nation's Health- a strategy for the 1990's', recommended that the number of women who breastfeed for a minimum of six weeks should be increased to 75%, and the regional variations in the patterns of breastfeeding should be eliminated. In a local hospital, only 48% of women apparently breastfeed during their stay (personal communication March 1996). The difference between the national target and the number of women who are actually breastfeeding locally, arguably provides local health professionals with a significant area of concern.

Given the gap between the WHO recommendation regarding breastfeeding and 'practice on the ground' this analysis intends to examine the potential of health promotion to effect change by firstly investigating the practice of breastfeeding. Part of the investigation seeks to identify the factors influencing breastfeeding uptake, following which the principles and values that underpin the current concept of health promotion can be examined in relation to the analysis on breastfeeding. Lastly current health promotion practice is analysed with the intention of determining how closely recommended practice is reflected in actuality.

In order to acquire a comprehensive understanding of the practice of breastfeeding it is necessary to consider the claim made by the WHO/UNICEF 1979 (cited in Hytten1991) which suggests that breastfeeding is 'ideal'. Hytten (1991) considers the statement is political rather than scientific. He suggests it disregards 'the possibilities of exceptions and individual variability.' (p.118). This reservation poses the question, Is there a scientific case for breastfeeding? The WHO/UNICEF statement suggests that breastfeeding is both 'ideal' and 'natural.' Scientific evidence for and against the case needs to be explored, and, as the WHO considers that breastfeeding has emotional and biological benefits both for mother and baby, it will be of particular importance to investigate these areas.

Having determined the strength of the case for breastfeeding, identification of the women who breastfeed may not only reveal whether the local picture is reflected elsewhere, but will also establish how closely breastfeeding in practice corresponds to the recommendations promoted by health promoters and health education literature. It will be relevant to consider research through which women have described the factors they feel influence their infant feeding practices. In particular, women's level of awareness of current scientific evidence relating to breastfeeding as an influence on their own practice needs to be identified, as the provision of written and verbal scientific information has always been an important part of health promotion activity. Analysis which examines the trends in breastfeeding over the past 200 years, identifies the women who breastfeed and compares the UK with that in other countries. This should identify whether breastfeeding is simply a random activity or distinctively patterned. Having examined, the relationship between the scientific recommendations for breastfeeding practice, further analysis to identify the factors that may impact on breastfeeding behaviour is necessary. With this understanding health promotion activity may be directed more appropriately.

In the next part of the investigation the framework of health promotion advocated by the WHO and embodied in the Ottawa Charter (1986) is examined in relation to the factors that have already been identified as influential on breastfeeding practice. Comparison between the determinants of health behaviour reflected in this model and those identified as impacting on breastfeeding behaviour is instructive in identifying both the similarities and the differences. The principle of empowerment that underpins the framework needs to be examined and the strategies proposed in the Ottawa Charter identified. At a theoretical level the potential for enabling strategies to effect a change in trends will be considered, while related difficulties will be identified.

The WHO/UNICEF statement was criticised by Hytten (1991 ) as being political rather than scientific. Kelly and Charleton (1995) would agree as they consider the WHO

does consider politicising health promotion is essential if a more supportive environment is to be created. This needs careful investigation as it suggests health promotion activity encompasses far more than information giving. A multi-disciplinary approach, with a variety of government departments cooperating with each other and with external organisations is more appropriate. The ability of governments to initiate social policy to effect change and their level of commitment to the current approach of health promotion is therefore a key issue for consideration.

At a more local level identifying the role of the health promoter is important. It will be instructive to examine the skills identified in the Ottawa Charter (1986) that the health promoter needs to empower women. To achieve this it is proposed that a selection of recent research relating to health promotion activity and breastfeeding will be investigated. As voluntary and statutory agencies have an involvement at local level it is pertinent that both are considered. For the health professional the recent changes in the organisation of the NHS, with its emphasis on the purchasing of services and the increased need to prove that services are cost effective, may have affected the way in which health professionals are either able or directed to work. This issue therefore needs to be examined while the potential for the NCT to operate appropriately needs considering.

The final issue to be explored relates to the use of target setting by the WHO. Increasing the number of women who breastfeed to 75%, (WHO 1991) appears to be an important part of the WHO strategy for implementing health promotion. As the 'mouth piece' of this health promotion framework, the WHO clearly feels targets are relevant. Are targets an incentive to health promoters or measurable goals that will demonstrate effectiveness? How beneficial is target setting for the client? These are questions which need careful examination.

By examining the theoretical potential of health promotion to effect a change in breastfeeding trends, and considering a selection of current health promotion practice it is anticipated that the analysis will begin to answer the questions raised, and comment on the potential of current health promotion approaches to influence trends in breastfeeding patterns.

## **Chapter 1- The case for the promotion of breastfeeding.**

Described as the 'natural' and 'ideal' way of feeding a baby, breastfeeding is considered to provide a 'unique emotional and biological basis for child development,' (WHO/UNICEF 1979 cited in Hytten 1991p.118). The WHO/UNICEF further suggest that breastfeeding prevents infection while it has benefits for the mother's well-being, particularly with regard to family spacing and the promotion of self reliance. Health professionals and health education literature, in consequence, promote the message that 'breast is best'. The purpose of this chapter is to investigate this claim. As there are considered to be distinct biological and psychological advantages to breastfeeding it is appropriate to investigate whether there are benefits, for both mother and baby, from these two perspectives.

### **Does breastfeeding have biological benefits for mother and baby?**

The biological benefits of breastfeeding are identified by the Department of Health as follows:

- 'a) All the nutrients are present in the right amount for human infants and in a readily absorbed form. Those nutrients which are low, such as iron and copper are those which are already stored in large amounts in the infant's liver.
- b) It contains several natural agents which protect against disease.
- c) It is clean, cannot be prepared incorrectly, and does not cause allergies.' (DoH 342,1993 p93)

The first claim that breast milk is produced in the correct nutritional form is well documented. The unique composition, the development of mature milk, and the changing nature of milk within one feed are all considered to benefit the newborn infant (WHO 1985). Arke (1991) goes further describing how its composition varies not only between mothers but in the same woman between the breasts. He reports that women feeding twins, who have a consistent breast preference, produce individually tailored milks uniquely suited to each child's needs.

The Collaborative Study on Breastfeeding (WHO1985) reports that colostrum, is also uniquely suited to the baby's needs. Arke (1991) describes the benefits of colostrum, a substance unavailable to those babies who are immediately bottle fed, as a unique high density, low volume fluid, high in protein, immunoglobulin and other protective features. Meeting the baby's

nutritional needs, it is also suited to the specific needs of the neonate's immature kidneys which cannot handle large volumes of fluid at this early stage (Arke 1991). Meanwhile the protective capability of colostrum is illustrated by the high sources of vitamin K it contains, a substance required for blood clotting and needed to prevent haemorrhagic disease of the newborn ( Kiles et al 1987 cited in Palmer 1993). While not disputing the main points of the argument, Hytten (1991) suggests that colostrum does not contain some of the protective capabilities with which it is associated. He considers that passive immunity, for humans, is achieved through the placenta. Thus, while the case for promoting the use of colostrum is strong, its function does not appear, as yet, to be fully understood.

However, many cultures noted for breastfeeding do reject the use of colostrum, considering it unclean or unwholesome. King and Ashworth (1991) describe how in Nigeria and the Caribbean medicinal teas are given to the baby instead. They have a purgative affect, as meconium is thought to be harmful, but are also given as they are considered to give and maintain the baby's strength and health. Meanwhile, it is not uncommon in India for the baby to be given honey and butter for similar reasons. This suggests that the decision to breastfeed has not been made in these instances from available scientific evidence, that other factors, often based on cultural beliefs, are influential when making decisions, a point that will be returned to later.

Comparing breast milk to infant formula reveals that the compositional differences are numerous. Over 100 changes are made to infant formula every year (Messenger 1994 cited in Inch 1994) in an attempt to create a food as near to human milk as possible. Taurine, a substance essential for the myelination of the central nervous system was added to infant formula as recently in 1984 (Inch 1994). Although babies have a large store of iron at birth, iron is added to infant formula in far larger quantities than that found in breast milk because, in the absence of the iron binding protein human lactoferrin found in breast milk, it is not well absorbed by infants (Inch 1994). These two examples serve to illustrate that the compositions of breast milk and infant formula are different. Concern though has been expressed by Wilson and Hamburger (1988 cited in Arke1991) about the antigenic responses which may be

generated by the use of a milk produced from an alternative animal source (cow's milk intolerance), an important consideration in an era when the numbers of children with allergic responses such as eczema and asthma are rising (Robertson et al 1991 cited in Primak 1995).

Regarding the protective nature of breast milk, it is suggested that breast milk provides passive immunological protection while the baby's own immune system is developing (Hanson et al 1988). Research suggests that breastfeeding protects the baby from eczema (Chandra et al 1989) and asthma (Hide and Guyer 1981). Evidence also suggests that breastfeeding reduces the incidence of the following diseases associated with childhood, coeliac disease (Auricchio et al 1983 cited in Hytten 1991), otitis media (Saarinen 1982), respiratory tract infection (Howie et al 1990), diabetes (Virtanen 1993) and sudden infant death (Ford et al 1993 in Inch 1994). Longer lasting benefits from breastfeeding have also been suggested, with evidence that breastfeeding promotes intellectual development (Lucas et al 1992) and prevents both Crohn's disease (Kolezko et al 1989) and multiple sclerosis (Pisacane et al 1994). Methodologically it is difficult to examine the cause of a disease, as the aetiology of disease is complex, involving as Seedhouse (1986) concludes, a wide range of causal factors. This is particularly the case when a gap of many years has evolved between the incidence of the disease and a named predisposing factor. Other influences must inevitably impact on the individual and may be equally influential. This makes it difficult to determine the full impact of breastfeeding on the incidence of the above diseases. Hence the reliability of such findings needs to be considered very carefully.

Perhaps this is best illustrated by the continual debate that surrounds breastfeeding and its potential to prevent heart disease, a link that remains unconfirmed. The low sodium levels found in breast milk have been thought to help prevent hypertension in later life (Dahl 1962 cited in Arke 1991) while the tendency to obesity in early childhood, thought to be associated with infant formula, has similarly been linked to adult heart disease. The difficulty of fully evaluating the relationship between early causation and later manifestation of disease is perhaps best illustrated by Hytten (1991) who concludes that the evidence is both muddled and contradictory. He cites the study by Fomon (1980) which indicated that obesity at 8 years was

not related to infant feeding methods while Kramer (1981) suggested that breastfeeding in infancy did protect adolescents against subsequent obesity. Meanwhile Inch (1994) cites the work of Joote et al (1991) who suggest that the levels of cholesterol in breast-milk are such that they stimulate the production of enzymes necessary in later life for cholesterol degradation, which may subsequently be beneficial in protecting against heart disease. Such is the confusion, it illustrates both the complexity of research and the need for further research to clarify the issue.

In one particular area of infant feeding there has been considerable evidence to suggest that breastfeeding is advantageous. It has been demonstrated that the risk of gastro-enteritis is considerably reduced in the breast-fed baby. Howie et al (1990) produced convincing evidence in Dundee, whilst Arke (1991) cites similar studies in Gambia, Sudan and Bangladesh. The concept that breast milk is clean because it needs no preparation refers to the contamination which may occur when preparing infant formulas, particularly in areas where hygiene standards are low (King and Ashworth 1991). It is also suggested that the protective nature of breast milk may again have an influence, in that, hypernatraemia associated with gastroenteritis is unlikely in the breast fed infant (Wharton 1992) as the sodium levels in breast milk are consistently low. Meanwhile infant formula feeds have been associated with high sodium levels, particularly if the feeds have been made inappropriately, a not uncommon practice according to the research of Jeffs (1989) as feeds may be too dilute or conversely too concentrated.

The evidence that breastfeeding protects a child against gastro-enteritis is very strong but that alone cannot solely justify the claim that breast milk is uncontaminated. The WHO in 1985 suggested that breast milk may now be affected with pesticides. Obviously it is difficult to predict the health impact pesticides may have for a baby's growth and development, but in Africa babies are known to be at risk of the toxic substance, aflatoxin (Lamplugh et al 1988). It is also known that viruses such as cytomegalovirus and HIV are secreted through breast milk (Arke 1991). While the former is thought unlikely to cause problems less is known about the effects of HIV and the WHO (1992) has urged caution in promoting breastfeeding to HIV



positive mothers in areas of the world where there is an appropriate and safe alternative. The recommendation of the WHO, about advice to women who are HIV positive, is perhaps the first official suggestion from those who influence health promotion that there are reservations about the benefits of breastfeeding in some situations. This comes at a time when the duration of breastfeeding has also been queried, with supplementary feeding being described as essential in the second 6 months of life both for the mother and baby. As Brakohpaipa et al (1988 cited in Wray 1991) report, it is around this time that the infant's diet should be supplemented if growth is to continue satisfactorily.

The evidence strongly suggests that, from the infant's perspective, breastfeeding is beneficial both in the short and long term. Infant formula does not replicate breast milk nutritionally, and while further research is necessary to understand more fully the protective nature of breast milk, the prevention it affords the baby to certain illness in general, and gastroenteritis in particular is convincing. In areas without clean drinking water to make the infant formula feed, a baby is 25 times more likely to die than a baby who has been fed exclusively on breast milk for between 4-6 months (UNICEF/WHO 1989 cited in Inch 1994). Not to breastfeed in such areas is dangerous, but in areas where the risks of gastro-enteritis are not as great the different composition between breast milk and infant formula still suggest that breast milk is, theoretically, the most appropriate choice for a baby.

The health of the mother is also of importance. Her well-being is to some extent likely to determine the health of the baby. The potential benefits breastfeeding has for the mother therefore need to be evaluated. As the WHO (1979) considered that breastfeeding was 'natural' it could be assumed that a woman would 'naturally' produce an adequate supply of milk. However Morrow and Barraclough (1993) suggest that between 1-5% of the female population may not be able to breast feed, while in western cultures this is thought to be much higher (Hyttén 1991). However, as Hyttén (1991) postulates, it is very difficult to research this particular aspect of infant feeding with absolute accuracy as the 'difficulty' of achieving an adequate milk supply, often cited as a reason for offering a supplementary source of food, may not have a solely biological explanation.

It has been suggested that breastfeeding aids both post-partum weight loss and contraction of the uterus. While the evidence of Brescher (1989 cited in Arke 1991) does suggest breastfeeding enables involution, the benefits associated with weight loss are less clear. Manning-Dalton and Allen (1983 cited by Worthington-Roberts and Williams 1989) suggest that while weight loss often occurs during breastfeeding, both the nutritional intake and the level of maternal activity and energy levels need to be considered, making further research necessary before conclusive evidence can be reported. More recently, Short (1993 cited in Inch 1994) reported that breastfeeding is likely to give protection from both breast, ovarian and endometrial cancer. Evidence suggests women who bottle feed are twice as likely to develop pre-menopausal breast cancer, while current research also suggests that breastfeeding may be one of the factors in helping to prevent osteoporosis (Aloia 1985 cited in Palmer 1993).

The value of breastfeeding as a method of contraception has long been discussed. Wray (1991) cites the research of Bongaarts et al (1983) who both suggest that 'breast-feeding has a far bigger impact on fertility than contraception does on all of Africa and Asia.' (p100). Breastfeeding, paradoxically, is seen as an important method of birth control in some parts of the world while in other areas health promoters suggest otherwise. Achieving contraceptive protection requires the baby to be fed a minimum of 6 times over a 24 hour period, in order to prevent ovulation (Tyson et al 1976), as the suckling of the infant at frequent intervals inhibits the production of prolactin (Short 1984 both cited in Wray 1991). As contraceptive protection can only be ensured by intensive and continual breastfeeding, in areas such as Britain, where early supplementary feeding is the norm (White et al 1993), it would be unlikely to offer any assurance of protection. However in the Third World, with less access to alternative forms of contraception, breastfeeding may offer the most appropriate protection from further pregnancy. Particularly, in countries where cultural beliefs consider sexual abstinence is appropriate during the postpartum period of amenorrhoea, for example in the case of the South American Indians, it provides an effective contraceptive (Ford and Beach 1953 cited in Hakanson 1992). In statistical terms Wray (1991) concludes that breastfeeding in Africa inhibits an average of 4 pregnancies, while in Bangladesh it may be as great as 6.5

pregnancies. Therefore in countries where contraception is neither accepted on religious or cultural grounds nor freely available, the decision to breastfeed may affect not just the well-being of the mother and child, but may also influence family size and therefore the well-being of the whole family.

From a biological perspective, there appears to be a strong case for promoting breastfeeding. The potential benefits for the baby appear to be numerous and while there are fewer advantages for the mother, these benefits cannot be ignored. The potential effects on population control and the incidence of breast cancer are of particular importance. Thus, with the exception of the estimated 5% of women who are unable to breastfeed and the women advised to use formula milk because of an infection risk such as HIV, there is considerable evidence that breastfeeding is a beneficial activity.

### **Does breastfeeding influence the emotional well-being of mother and baby?**

The emotional benefits ascribed to infant feeding relate to the development of the relationship between mother and child usually referred to as bonding or attachment. Leach (1994) considers that attachment occurs as a result of the activity of breastfeeding rather than the breast-milk itself. She suggests that close body contact, the use of touch/stroking and the importance of the activity being infant-directed can help develop a bond between mother and child. Bottle feeding could also incorporate all these features but not the biological feature that Laufer (1990) describes. She reports that oxytocin secreted during breastfeeding stimulates a feeling of tenderness and affection.

The benefits of bonding have been acknowledged for some time. Klaus and Kemmel in 1970 (cited by Palmer 1993) considered that babies needed close bodily contact from an early age, which would be best achieved through breastfeeding, while even earlier, Bowlby (1965), considered that there may be long term consequences for the child's emotional well-being if bonding was impaired. He emphasised the importance of building up and maintaining a relationship with one carer, a recommendation which is possible for a woman who bottle feeds.

Inevitably it is difficult to evaluate the life long consequences of a feeding method on a child's long term emotional development when so many other factors impact on a child's emotional well-being, but Silva et al (1976 cited in Hytten 1991) in a prospective study of 1037 children, showed that there were no behavioural differences at 3 years between those who had been breast-fed and bottle fed when the evidence was matched for such characteristics as maternal socio-economic status and education. Bonding, for the baby, can therefore be achieved with both breastfeeding and bottle feeding. It is the quality of the experience and the kind of relationship which develops in consequence which appears to be all important.

Perhaps bonding is more important for the mother, although given the close physical relationship between mother and baby any feelings of emotional well-being engendered by the mother might be transferred to the baby. Myer (1981 cited in Laufer 1990) suggests that confidence enhances maternal feelings, while research demonstrates that a confident attitude increases breastfeeding success (Buxton et al 1991). In contrast Tamminen and Salmelin (1991) describe how depressed mothers exhibit a distinct lack of satisfaction in mother-infant interaction. They demonstrate both a lack of sensitivity to the child, a lack of eye contact, and are less successful at breastfeeding. It has been reported that 15 % of women suffer depression post-natally (Alder and Bancroft 1983) and similar reactions are also experienced by those women who are anxious (Soo et al 1988). Such evidence suggests that a confident woman, more likely to be successful at breastfeeding, will be able to develop an increasingly deeper bond with the baby, which, while further enhancing her own self esteem, will provide a firm basis for the future mother/child relationship. Conversely depression or anxiety is likely to inhibit bonding, lessen maternal self esteem and make breastfeeding more difficult. Breastfeeding therefore does not universally, appear to encourage feelings of self reliance as suggested by WHO/UNICEF (1979 cited in Hytten 1991).

Given this evidence it appears that the emotional benefits for the mother can be measured by the pleasure the mother gains from the breastfeeding experience. Hytten (1991) reports that many women who breastfeed will state it has been a rewarding experience, emphasising feelings of pride and satisfaction. Hills-Broncysk et al (1994) also report, that women who

have breast-fed for over 12 months consider breastfeeding is a special time when they feel a mother/child bond. Similarly, Locklin and Naber (1993) describe how women who continued breastfeeding against considerable odds, either because of poor health or adverse social pressure, reported that the attachment between themselves and the baby was very important. For such mothers and babies, breastfeeding could be said to have positive psychological benefits.

However as evidence demonstrates not every woman enjoys or wants the experience. Oakley (1974) described how women felt guilty because they found the idea of breastfeeding nauseating, while Price (1988) reports that many women, particularly with low self esteem, say they dislike the experience, find it difficult to cope, yet feel too guilty to give up. These points illustrate that breastfeeding does not afford similar emotional benefits to all women. The potential influences on patterns of breastfeeding are examined further in Chapter 3. Meanwhile it can be concluded that any emotional distress for the mother may well be passed onto the baby. The importance of bonding/attachment is not under debate. It is reasonable to suggest that a pleasurable and rewarding breastfeeding experience for the mother will be of mutual benefit. However, for those women who find breastfeeding neither pleasurable nor rewarding there may be few emotional benefits. In consequence infant formula, given by a contented and happy mother, may promote a better relationship between the mother and baby, safe in the knowledge that bottle feeding can give long term emotional benefits (Silva et al 1976 cited in Hytten 1991).

Chapman (1993) suggests that 'the importance of breastfeeding must be acknowledged.' (p168). From a biological perspective there are very strong arguments for promoting breastfeeding. Breast milk can be described as the 'ideal' food for the baby and mother, and attempts to reproduce an identical infant formula have so far failed. Both its nutritional benefits and protective capabilities are superior to those provided by infant formula. Whether breastfeeding as an activity can be said to be 'ideal' is however less convincing as the emotional feelings of well-being that the activity of breast-feeding generates are not universal. For many women and babies it will be a beneficial experience, but for other women, for a variety of reasons, the

activity of breastfeeding may be unrewarding and/or difficult. In consequence while breast milk's character as a 'natural' product cannot be denied, breastfeeding as a 'natural' activity is questionable. Both for the estimated 5% of women who are unable to breastfeed and those women who find breastfeeding a less than satisfying experience it will appear neither 'ideal' nor 'natural'. Health promoters need, therefore, to have a good understanding of the current scientific evidence relating to breastfeeding. This will enable them to both understand that breastfeeding may not be an activity that suits all women, yet allow them to give clients accurate information about the medical 'benefits' of breastfeeding.

## **Chapter 2-Trends in breastfeeding.**

The previous chapter has demonstrated that there is a strong, though not universal, case for breastfeeding. The nutritional benefits to the baby and evidence that breast milk offers protection against disease in both the long and short term for both the mother and baby are identified as two of the principle advantages, while for some women breastfeeding facilitates the development of strong feelings of attachment (Locklin and Naber 1993). Based on evidence such as this, and the evidence that 'foreign' substances should not be introduced too soon, it is understandable that the COMA Report (1994) recommends that women breastfeed and avoid the introduction of solid food until 4 months. The purpose of this chapter, is to identify which women in practice initiate breastfeeding and how long they continue to breastfeed, seeking to identify trends in breastfeeding activity. This will allow a comparison to be made between recommended and actual breastfeeding activity, and will provide an appropriate basis for further analysis, which seeks to identify the factors influencing breastfeeding activity. To fully explore the patterns of breastfeeding activity it is instructive firstly to, identify the changes that have occurred in the practice of breastfeeding over the past two hundred years; secondly, to identify current breastfeeding patterns in Great Britain; and lastly to consider whether similar trends are apparent in other countries.

### **Collating research evidence.**

Retrospective research over two hundred years is difficult as records may be incomplete or difficult to validate. Current research can also be problematic in terms of the accuracy of self reporting and definition of what is meant by 'having breast-fed'. Helsing and Saadel (1992) consider that in many countries breastfeeding still has a relatively low priority and that poor collation of data, with a small number of participants, make it difficult to estimate national trends. In Great Britain the DoH has,

since the 1970s, commissioned three large research projects to investigate the question of infant feeding. In the last study, 'Infant Feeding 1990' (White et al 1992), three retrospective questionnaires were sent (at 6 weeks, 4 months and 9 months) to the homes of the 9064 women. There was a response rate of 88%. White et al (1992) are quite specific about the interpretation they put on their questions making it easy to compare this study with the previous studies commissioned by the Government.

In general, comparisons between studies can be difficult. Reference to the 'incidence of breastfeeding', needs a clarification of the term. For example, it could refer to a baby who has only been breast-fed on one occasion, while the duration of breastfeeding may involve a baby who may not just be breast-fed but who has also been given infant formula and solid food during the same period. In the former case, in retrospect, the baby could really only be described as artificially fed, while in the later case the breast milk may only represent a small part of the child's daily nutrition (White et al 1992). Meanwhile, as Helsing and Saadel (1992) report, any time between 61 days and 119 days could be defined as 3 months. These methodological complexities need to be recognised.

### **Patterns of breastfeeding over the past 200 years in Britain.**

Literature demonstrates, that in pre-industrial Britain babies were almost always 100% breast-fed (Fildes 1986). The employment of a wet nurse, a woman of a lower social class, was common practice for the babies of upper class women and for babies whose mothers had died in childbirth, or for some reason were unable to feed their infant. Fildes (1986) suggests, that throughout the 19th century the effects of the industrial revolution brought about an immense change in lifestyle which radically altered the infant feeding practice of the pre-industrial era. The patenting of condensed milk in the 1860s appears to have initiated the development of an acceptable alternative to breast milk (Inch 1994). It would appear that breastfeeding began to decline from 1870



onwards (Fildes 1991), with the incidence of breastfeeding between the urban and rural areas beginning to differ (rural areas retained an almost 100% record of breastfeeding). Explaining these changes Fildes (1991) provides as evidence that the location of hospitals in the towns and cities meant medical services were beginning to become available to the local inhabitants, while developments in science were leading to a better understanding of nutrition, both of which led to medical intervention and experimentation with infant feeding. Lewis in 1980 (cited by Campen 1993) reports how by 1883 there were 27 brands of milk on sale for infants, all of which he would now describe as unsuitable for infants.

At that time many women were also employed to work in the factories. Particularly in the northern towns and cities, a woman could return to work soon after the baby's birth. Unlike the mothers in rural areas who frequently worked at home, work in the town meant separation of mother and child. Fildes (1991) identifies Liverpool in 1890 as having an average breastfeeding rate of only 50% while rural areas could be as high as 98%. She also observes, that migrant groups to the city of Liverpool, such as the Irish, continued to totally breastfeed in higher numbers than the indigenous population, suggesting that they must have been influenced by different factors.

Middle class women gradually chose to bottle feed rather than use a wet nurse (Fildes 1991). By the early 20th century medical books and health education literature wrote extensively about artificial feeding with minimal reference to wet nursing and little reference to breastfeeding. Even the provision of infant formula in Child Welfare Clinics suggested it had the support of the medical profession. Generally then the trend in breastfeeding was one of gradual decline until the period of 1910-1919, when there was world wide concern about high infant mortality rates and their apparent link to infant formula (Fildes 1991). Campen (1993) describes how in 1903 research showed that out of 116 babies who had died with gastroenteritis only 5 had been breast-fed. Health education campaigns followed, and appear to have been credited

with success, as initial breastfeeding rates rose from 72-94 %. (Campen 1993). However the pattern was not completely reversed as women did not feed for as long a period of time ( Fildes 1991), and moreover, this improvement did not last. At the beginning of the century 80% of women breast-fed and this gradually fell to an all time low in 1970, of around 14% , by which time Britain could no longer consider itself a breastfeeding nation.

From the 1970s onward however the picture appears to have changed. The first COMA Report (DHSS 1974), spoke out strongly in favour of breastfeeding. It reported that only 31% of Scottish women initiated breastfeeding with 16% of those women transferring to an alternative food within a month, while only 5% were still feeding at 4 months. A similar low uptake appears to have been recorded in other areas of Britain. Wharton (1992) considers that this report was the catalyst for a vigorous health education campaign to promote breastfeeding. Subsequently, research has been collated through large retrospective studies similar to the current research of White et al (1992). Martin (1978) showed that 51% of women initiated breastfeeding in 1975, rising to 67% in 1980 (Martin and Monks 1982), while in 1985, 65 % breast-fed (Martin and White 1988). Thompson (1991) suggests that in 1975 regional differences were apparent with only 41% of women breastfeeding in the north and 62% in the south while by 1980 this had become 59% and 76% respectively.

Overall there has been a gradual decline in the number of women who breastfeed with less women breastfeeding in the early 1970's than ever before. The upturn in the later part of the decade has subsequently been followed by another gradual decline with 2% less women breastfeeding in 1985 than 1980.

**Current trends in breastfeeding.**

The most recent comprehensive research into the current patterns of breastfeeding, Infant Feeding 1990 (White et al 1992) reports that in 1990 63% of women breast-fed initially, a further fall of 2% since 1985. The following tables illustrate how this number changes over subsequent weeks and with subsequent pregnancies.

| Birth | 1 week | 2 weeks | 6 weeks | 4 months | 6 months | 9 months |
|-------|--------|---------|---------|----------|----------|----------|
| 63%   | 53%    | 50%     | 39%     | 25%      | 21%      | 11%      |

Table 1. Prevalence of breastfeeding in Great Britain 1990  
(White et al 1992)

| First birth | Second birth | Third Birth | Fourth and later<br>Birth |
|-------------|--------------|-------------|---------------------------|
| 69%         | 59%          | 58%         | 52%                       |

Table 2. Incidence of breastfeeding by birth order in Great Britain 1990.  
(White et al 1992p.9)

Whilst the number of women who initially decide to breastfeed is 63% (Table 1), the number of women who are still breastfeeding at the recommended 4 months (DHSS 1994) is 25%. In Table 2, the figure given for the first child and subsequent children reveals that a woman is more likely to breastfeed her first child than subsequent children. White et al (1992) report that if a mother breastfeeds her first child she is likely to breastfeed again, while a woman who bottle feeds her first child is extremely unlikely to breastfeed her second baby. The method of feeding adopted with the first

pregnancy appears to influence the feeding method in subsequent pregnancies, although the gradual decline in breastfeeding with subsequent pregnancies suggests that different factors may also be influential. They further suggest that the sex of the baby has no influence on the initiation or duration of breastfeeding. Nevertheless, in Scotland, where women show no difference in their preference initially, they were more likely to breastfeed female babies after 6 weeks. At 6 weeks Scottish women were breastfeeding 63% of girls against 56% of boys, with a similar difference still apparent at 9 months (22% and 16 % respectfully).

To investigate the incidence in more detail, it is necessary to see if there are any common links between the 63% of women who do decide to breastfeed. White et al (1992) identify a number of factors influencing breastfeeding uptake today. They conclude that 89 % of woman in social class 1 will breastfeed compared to 50 % of woman in social class 5, while if the woman has neither a husband nor a partner the figure falls even further to 47%. Those women who do initiate breastfeeding in the lower social groups will give up feeding earlier. At 4 months, of those who started breastfeeding in social class 1, 56% will still be breastfeeding, while in social class 5 only 23 % will have continued. White et al (1992) also demonstrate that the breastfeeding rate is higher for women who have been in full time education until 19 years of age (93% as opposed to 57% for those leaving full time education at 16 years of age). They also identified an age effect, with 86% of women breastfeeding if over 30 years of age and 39% if less than 20 years of age.

While observing that maternity leave status is often linked to social class status, White et al (1992) considered whether employed women were less likely to decide to breastfeed, but concluded that 'an early return to work did not significantly deter women from breastfeeding initially' (p13). They reported that 59% of women on maternity leave decided to breastfeed and concluded that the survey 'provides no evidence that returning to work significantly shortens the time for which a mother

breastfeeds' (p.28). Women who smoke are less likely to breastfeed with 47% against 69% of non smokers. The historic regional differences still persist with 74% of babies breast-fed in London but only 50% in Scotland.

This regional difference raises another issue which White et al (1992) have not addressed. At no time have they considered the differences that cultural beliefs may have on the patterns of breastfeeding in Britain today, an issue that has already been raised in Chapter 1. Osborn and Butler (1970 cited in Ineichen 1995) reported following a national survey wide variations in the rates of breastfeeding between ethnic minority groups, with 77.5 % of Afro-Caribbean women breastfeeding initially, against 45.6% among the Indian and Pakistani mothers. Ineichen (1995) states that similar findings have also been found in the 1980s. He does not report whether there is a gender bias in those children that are breast-fed but given the status of the male Indian child in relation to the female Indian child it is possible this may be the case.

A study in Sheffield, conducted by Emery et al (1990) between 1979-1988, not only provides evidence to support White et al (1992), it also demonstrates the breastfeeding trends of the ethnic minority women in the city. It reports how in 1982, 70% of women expressed an intention to breastfeed but at one month only 40% had continued. By 1988 they reported an almost 10 % fall in the number of women intending to breastfeed while at one month only 32 % were still breastfeeding. This fall in numbers was not evenly distributed throughout the city as those women in privileged areas showed figures that have remained almost static, while there appeared to be a significant fall in the number of Asian women who were considering breastfeeding. During the 10 years the number of Asian women who breast-fed peaked in 1984 when 70 % initiated breastfeeding but in 1988 this figure had fallen to 53 %, significantly less than the 63 % of white women who intended breastfeeding.

This supports the evidence presented by White et al (1992) that women in higher social groups who left school later are more likely to breastfeed, while highlighting a cultural difference that would need further research before that particular trend could be fully understood. Unable to identify a specific reason for the decline, Emery et al (1990) comment, that while they accept there are many influences on breastfeeding uptake 'the decline had taken place when the city itself was under stress from unemployment' (p.372), a point that will be revisited in Chapter 5.

Research has revealed that the practice of breastfeeding in Great Britain shows quite distinct patterns. It is not a random activity. The gradual decline in the number of women who breastfeed means that a typical breastfeeding woman has emerged, being older, better educated, with a partner and probably a member of social class 1 or 2. Comparison needs to be made with other nations to see if the trends elsewhere are as distinctive as, and similar to, those found in the UK.

### **The international trends in breastfeeding.**

From an historical perspective, breastfeeding trends in the USA show a similar pattern of decline to those in Britain with only 38% breastfeeding in 1946 and 18 % in 1966 (Meyer 1968 cited in Silverton 1985). Today, 52% of all American women breastfeed but, similar to the U K, this figure drops to 29% amongst those women in the poorest circumstances, with an even lower figure of 23 % for women who are black and poor (Libbus and Kolostov 1994).

In Europe (IBFAN 1986 cited in O'Leary 1987) Germany reports an initial breastfeeding rate of 70-80% with 10% continuing to 6 months. Sweden has 91-93% of women breastfeeding at one week with 13-17% continuing to 6 months, while Ireland, in contrast, has an initial rate of only 29% with only 3-4% continuing to 16 weeks. Meanwhile in Norway, which had a breastfeeding rate in the early 1970's

comparable with that in the UK, 99% initiate breastfeeding with 90% partially breastfeeding at 4 months (Erlichman 1995). France with an initial breastfeeding rate of 58%, reports like Britain wide regional variations in the incidence of breastfeeding with 82% breastfeeding in Toul as opposed to 40% in Loire-Atlantique ( Helsing and Saadel 1991).

In areas of the third world UNICEF (1995) reports wide variations between countries. In Africa, 97% breastfeed in Kenya compared with 57% in Ghana, while in Asia, Thailand reports a rate of 69% with Pakistan as low as 29%. Comparisons are difficult due to the inaccuracy and incompleteness of data. The high rate of breastfeeding recorded in Kenya masks the fact that supplementing food is introduced very early particularly in the urban areas, with only an estimated 11% still being totally breast-fed at 3-4 months (King and Ashworth 1991). In India where traditional infant feeding practices are characterised by not allowing the baby colostrum, and supplementation delayed until 6 months of age or later, since the 1970s, there has been an increase in the number of children who are both bottle fed and given supplementary foods earlier, particularly in the urban areas and amongst higher income mothers. (King and Ashworth 1991).

The data reveals that distinct trends are apparent in each country. The trend in Norway appears to be exceptional in that few women bottle feed, while in Sweden with a similar initial breastfeeding rate the duration of breastfeeding is poor. Therefore with the exception of Norway, most countries in the western world show similar historic and current trends to those found in Great Britain. Many infants are never breast-fed, and of those babies who are breast-fed many do not receive breast milk for the recommended 4 months. Thus the trends in breastfeeding are not consistent with current medical recommendations in the UK. Over the last century, in the western world, there has been a gradual global decline in the number of women who breastfeed, with a similar decline now being demonstrated in the Third World.

In Britain, less women are breastfeeding every year. As White et al (1992) describes, the 'typical woman' who breastfeeds is older, has been in full time education until 19 years of age, is a non smoker, is a member of social classes 1 or 2, has a stable relationship and is more likely to live in the south. Having made the decision to breastfeed her first child for at least 3 months, she will in 97% of cases repeat the experience with another baby. Why this woman breastfeeds while other women use an infant formula needs further investigation. Identifying why the practice of breastfeeding is patterned in this way is important in examining health promotion's part in influencing the trends.



### **Chapter 3- Identifying the factors which impact on breastfeeding**

Identifying the trends in breastfeeding has demonstrated that generally there is a global decline in breastfeeding activity. In Britain the percentage of women who start breastfeeding has fallen by 4% since 1980 (White et al 1992). The clear picture of a typical breastfeeding mother identified in the previous chapter has demonstrated that breastfeeding is not a random activity. The evidence that many women do not comply with the medical recommendations relating to breastfeeding suggest that a woman's actions are not necessarily based on medical opinion. This poses the question as to why, if breastfeeding is as good for infants as the evidence discussed in Chapter 1 suggests, the patterns in breastfeeding practice are so structured. What other factors impact on the practice of breastfeeding? The purpose of this chapter is to analyse the trends already identified and review the research which has asked women themselves about breastfeeding. This will help inform health promoters of the areas where health promotion activity is needed, and how it might be tackled.

#### **An analysis of the trends in breastfeeding.**

From the research Fildes (1986) has undertaken into the historical trends in the practice of breastfeeding she suggests that the reduction in breastfeeding activity has occurred in conjunction with the development of industrialisation. She describes two differing experiences; first children totally breast-fed in rural areas and second, babies in industrial northern towns who were breast-fed in the morning, fed solid diet and opiates to keep them quiet during the day and usually unsuccessfully breast-fed during evening because they would be too sleepy to suck. The differing experience for these babies occurred because of women's need to work. Work in the towns meant going to a factory whereas in the country work was often sited in the home.

The WHO/ UNICEF (1990 cited in Helsing and Saadel 1991) consider that in some countries women who go back to work are more likely to breastfeed, a view not dissimilar to White et al (1992). Birenbaum et al (1989) would concur. Reporting from Israel he found that work, for well educated women, did not impact on the decision to breastfeed but the timing of returning to work and facilities available could influence the duration of breastfeeding. Meanwhile Winikeff and Baer (1980 cited in Carbello and Pelto 1991) found that, while women seldom cited returning to work as a reason for not breastfeeding, in Thailand, Indonesia, Columbia and Kenya an early need to return to work did affect both the decision and duration of breastfeeding. The impact of work in the initiation and duration of breastfeeding is therefore a complex issue. It suggests that work alone is not the sole issue but the length of maternity leave and access to child care facilities may also be influential, with those women who are better educated, in a higher income bracket, with possibly better maternity leave, more able to overcome the barrier that work itself presents.

Levine (1988 cited Carbello and Pelto et al 1991) concludes that formal work apart, demands on a woman's time directly affected the duration of breastfeeding. This being the case, it is logical to conclude that the decline in the incidence of breastfeeding with subsequent pregnancies (White et al 1992) can occur as a result of the increased demands on the woman's time when caring for a larger family. Given the demands of time on single parents who may have less assistance, this may explain why they are less likely to breastfeed.

The 'typical' breastfeeding woman, mature, better educated and living in a stable relationship provides a contrast to the woman least likely to breastfeed who is young, less well educated and unsupported (White et al 1992). They compare with the Vietnamese women that Sharma et al (1994) studied. While these women would have been likely to breastfeed in their own country, as recent arrivals to the UK, they spoke little English, lived in poor circumstances and had none of the supportive social family

network that they would have been likely to experience at home. Sharma (1994) reports that first born infants were not put to the breast at all. With little support at home and poor communication skills the women were also unable to gain appropriate support from health staff.

Hewat and Ellis (1986) also conclude that appropriate support is essential. The women in their study reported how their partner's emotional, psychological and physical support was particularly beneficial, with evidence demonstrating that the quality of support the women receives influences the duration of breastfeeding. In contrast, Hakansson (1992) identifies that some men experience negative feelings towards breastfeeding, as it raises feelings of jealousy and disgust, and in consequence would not encourage their partner to breastfeed. McIntosh (1985) who researched the choice of feeding method among working class women found a similar peer pressure to conform. He reports that often the mother's recommendation to bottle feed was based on practical issues such as the help she could give with the feeding, or her feelings that the house was too crowded for breastfeeding, as there was little privacy. In conjunction with these practical considerations the fact that there was no family tradition of breastfeeding was also cited. He found that the woman's mother was the most influential person with 91% of the women taking her advice. Le Fevre (1987) concurs, concluding from his research that partners and mothers are the only individuals who significantly influence the method of feeding. Support and expectation from family and friends does therefore appear to have a major impact on both the initiation and duration of breastfeeding. This is a point which has particular relevance to the health promoter as it means that both the woman's partner and/or mother need to be included when organising health promotion activity.

Referring back to the Vietnamese women, Sharma (1994) concluded that being first time mothers, they were not as confident in their ability to breastfeed. Buxton et al (1991) conclude that women who doubted their ability to breastfeed transferred

quickly to bottle feeding. Chapman (1993) suggests that confidence about handling one's own body as well as confidence in one's ability has an important part to play. Again low self esteem, as discussed earlier influences breastfeeding success. Soo et al (1987), who reported that anxious women and women suffering from anxiety states were less likely to establish and maintain breastfeeding, speculate that such women may find infant feeding less worrying if they can see and measure the amount of food the baby drinks at each feed, achievable only when bottle feeding.

In conjunction with the social changes that were a consequence of the industrial revolution, Fildes (1991) also suggested that the development of medicine, with its provision of a health service, and the development of processed milks influenced the change in feeding patterns. Carbello and Peltó (1991) suggest that both the availability and marketing of a breast milk substitutes must be a continuing source of influence on breastfeeding. Fisher (1985) from her research suggests that bottle feeding has led women 'to think of infant feeding in terms of volume consumed' (p51). She concludes , like Soo et al (1987), that women feel more secure when they can calculate the baby's daily intake. She also describes how text books and literature have suggested both bottle and breast-fed infants feed with their mouths in a posture inappropriate for breastfeeding but satisfactory for bottle feeding. This leads her to postulate that, as bottle feeding has now been firmly established for two generations, it is often the visual aspects of bottle feeding that are imprinted in people's minds. Meanwhile, Baisch et al (1989) reports that previous exposure to breastfeeding encourages women to breastfeed either because they had been breast-fed themselves, or heard about breastfeeding from their families. As such it appears that women are influenced by subtle visual, aural and verbal images embedded in their particular social environment. From her research into medical and midwifery text books Fisher (1985) concludes that the information on which health professionals have based their practice is often inaccurate and has frequently been counterproductive in establishing breastfeeding. She considers that the restrictive feeding routines advocated earlier in the century

severely limited the chances of breastfeeding being successful. Garforth and Garcia (1989) report that this advice still persists while other advice was often conflicting and counterproductive in enabling the establishing of lactation.

Analysis of the patterns of breastfeeding has revealed that the influences which impact on the practice of breastfeeding are both varied and complex. The support/expectations inside the home, the restrictions of work and lack of time are social factors that influence the patterns of breastfeeding while the woman's level of confidence and self esteem also impact on infant feeding practice. Meanwhile the availability of infant formula and less than helpful advice and support from the medical profession has encouraged over the years a bottle feeding 'culture' to develop, which is now firmly embedded in western society.

### **The practice of breastfeeding - women's view.**

Firstly it appears appropriate to find out why women breast or bottle feed. White et al (1992) report that, of those women who breastfeed, 88% considered it was better for the baby, 41 % felt it was more convenient, 21% considered it encouraged bonding and 18 % felt it was cheaper. Meanwhile those who bottle feed offered the following reasons, 47 % stated that other people could feed the baby, 28 % said they did not like the idea of breastfeeding, 10 % said they would be embarrassed to breastfeed, while 8% of women said they would be returning to work soon and they liked to see how much the baby was taking. White et al (1992) stress that women seldom cite one reason, but for those women who do breastfeed it can be seen that a dominant motivating factor is the belief that breast milk and the activity of feeding has particular health benefits.

Women who intend to bottle feed at no time intimate that infant formula is superior. McIntosh (1985) reports how 40 % of women who bottle feed acknowledge that

breast milk is superior while Chapman (1993) considers that the reasons given for bottle feeding are often of a practical nature. The view that other people can feed the baby, or there is a need to return to work, reflect a position which is in effect critical of breastfeeding rather than pro-bottle feeding. While breastfeeding mothers state that breastfeeding is convenient the bottle feeding mothers are implying a similar claim. Breastfeeding women dislike the idea of preparing feeds, while bottle feeding women feel the baby can be fed more easily in public (McIntosh 1985) and feeding is not entirely dependent on the mother. The mother's interpretation of the activity is based on beliefs held by the mother that she is adopting the best method for herself and her baby, hence the interpretation of 'convenient' can be rationalised to suit both methods (Weller and Dungy 1986 cited in Carbello and Pelto 1991).

Hewat and Ellis (1986) would concur. Their research suggests that many factors influence women and their decision is based on a number of beliefs. They report that ambivalent feelings were expressed by all the mothers in their study of breastfeeding women, from delight at the feelings of attachment, to reflections that breastfeeding was not easy. They suggest that the more the positive beliefs outweigh the negative beliefs the longer the duration of breastfeeding. Dislike and embarrassment were two views of breastfeeding expressed by bottle feeding women. Research suggests that this is not an uncommon reaction. Gregg (1989), having interviewed teenage women in Liverpool, found that 33% of the women felt that breastfeeding was rude and should be a private act. McIntosh (1985) reports that women describe breastfeeding as 'animal like' and distasteful, while Locklin and Naber (1993) found that young women from minority groups felt it was both old fashioned and would tie them down. Such an adverse reaction to breastfeeding offers another explanation as to why young women are less inclined to breastfeed.

Salt et al (1994) demonstrate how beliefs vary between regions. Their comparative study between Salisbury and Durham reveals that attitudes vary from area to area,

with a lower incidence of breastfeeding in Durham accompanied by a higher reporting of embarrassment and evidence that breastfeeding was less socially acceptable. The feeding of babies in public will be discussed more fully in Chapter 5 but Van Esternik (1989) does offer an explanation which she considers may be an important influence on breastfeeding. She looks to the research of Jellife and Jellife (1978) who considers that westernisation is associated with a shift in emphasis from the nurturing function of breasts, to a primary aesthetic and sexual function, which ultimately discourages women from feeding in public.

Having asked women what influences their decision to breastfeed it is important to identify any problems they experience which may affect the length of the breastfeeding period. White et al (1992, Table 1 p.20) report that of those women who gave up in the first 6 days, 47 % reported they had insufficient milk and from the first week until 4 months at least 50% cited the same reason. During the 1st week painful or engorged breasts were mentioned by 24 % of the mothers while other reasons for giving up feeding included disliking the experience and feeling too tired. At 2 months 14 % of mothers gave up to return to work. White et al (1992) report that this was an increase on the previous study in 1985, as more women were now on maternity leave.

The principal problem of insufficient milk is surprising given that with the exception of an estimated 5%, most women should be able to produce an adequate supply of milk (Morrow and Barraclough 1993). As discussed earlier, it is difficult to explain this anomaly. Carbello and Pelto (1991) record that there is very little data to identify whether there is a biological or a perceived insufficiency. They suggest that it is the mother's interpretation of the child's behaviour that leads them to that conclusion. They cite the study of Duthrie (1983) which demonstrated that crying and restlessness was frequently interpreted as hunger. This leads Carbello and Pelto (1991) to conclude that a lack of confidence and anxiety about the welfare of the baby may influence their decision to change to an infant formula. McIntosh (1985) found a similar pattern in his

research and concluded that the decision to stop feeding was often taken due to a lack of knowledge that breastfeeding takes several weeks to become properly established, an important point for the health promoter.

This poses a further question, linked to the earlier observation that adequate support was needed to encourage breastfeeding. Who do women identify as their main source of advice and support? It has already been established that women are influenced by their partner, family (especially mother) and peer group (Hewat and Ellis 1986). Do they also seek support and advice from health professionals? White et al report (1992) that attendance at antenatal class is closely associated with social class (82% of 1st time mothers in social class 1 attend, as opposed to 36 % in social class 5, when the woman has no partner). An overwhelming 99% had been told about breastfeeding but feeding preference is usually decided before women become pregnant and attendance at antenatal classes does not alter the woman's initial decision (Redman et al 1991) .

McIntosh (1985), whose study involved working class women concludes that their most important source of advice was the immediate family. He postulates that the preference for informal advice was, in part, due to the fact that it reinforced the woman's own beliefs, while he also acknowledges that women considered personal experience was superior to theoretical knowledge. This concurs with the evidence of King and Ashworth (1991) earlier, that cultural beliefs can be more influential than scientific opinion. Nevertheless McIntosh (1985) does indicate that those women who did seek advice from the health professional were more likely to breastfeed. However research into the quality of advice women receive from health professionals reveals that women are often critical, feeling advice is inaccurate and/or conflicting (Rajan 1993). Buckell and Thompson (1995) would concur. They investigated the level of support given to women in hospitals in two separate areas. In one area 48% of women, many of whom gave up breastfeeding, felt that they did not receive enough help, while advice was conflicting. In contrast 81% of women who breast-fed for 3



months considered the support had been adequate. Such criticism needs careful investigation and will be examined further in Chapter 6.

Current breastfeeding activity does not follow current medical recommendations as many babies have never been breast-fed, while others are only fed for a short period. Research has revealed that the patterns of breastfeeding are clearly defined with the better educated, older woman in social class 1 or 2 more likely to breastfeed, reassured by the belief that 'breast is best'. In marked contrast many women, particularly in the lower social groups, do not breastfeed even though they acknowledge the superiority of breast milk. This analysis has revealed the complexity of the factors that impact on the practice of breastfeeding. The social changes that have occurred as a result of industrialisation have influenced the current trend. Employment, demands on women's time and family support are of particular importance, with the greater barrier to breastfeeding being experienced by those women in the lower social groups. The effects of science and technology, by providing a viable milk substitute and the development of medical care, have both been influential; while the beliefs and attitudes which influence the decision to breastfeed appear to be governed by complex social factors deeply embedded in society. Women believe they make an independent choice, however in reality social and cultural forces are so strong that this does not appear to be the case, a fact that health promotion must recognise if it is to be influential.

## **Chapter 4- Does health promotion offer a way forward?**

The current weight of scientific evidence strongly supports breastfeeding in terms of its benefits both for the mother and child, yet, in recent years, there has been a global decline in the number of women who breastfeed. This appears to be the result of the social changes incurred by industrialisation, and the development of both science and technological knowledge. These complex forces have gradually established a bottle feeding culture as the 'norm'. The review in the previous chapter demonstrated that the practice of breastfeeding appears to be influenced by a woman's social circumstances, the provision of medical care and the availability of breast milk substitutes.

The purpose of this chapter is to examine the potential of health promotion to effect change with regard to breastfeeding. In order to examine this question it is first necessary to consider the concept of health promotion itself. Identifying the determinants of health is important, so a comparison with the empirical evidence regarding breastfeeding activity can be made. Given that there is a similar understanding, it is then necessary to examine the current principles and values that underpin the current concept of health promotion. Analysis of the strategies proposed by the Ottawa Charter (1986) is required, as it is the framework of health promotion the WHO considers most appropriate. The strategies need to be identified and then examined to determine, firstly, whether they reflect current research evidence, and secondly, whether they have the potential to alter breastfeeding patterns by drawing on the analysis developed thus far.

### **The development of the current conceptual framework for health promotion.**

Development of the current framework for health promotion has occurred, in part, as a result of the health care crisis in the 1970s (Ashton and Seymour 1988). Previously a framework for health education had been initiated in 1948 with the establishment of

the National Health Service. It relied on a high standard of hospital health care, requiring technological advances to cure illhealth, rather than addressing the actual causes of illhealth. Whilst redirection (from a political perspective) appears to have been governed by the need to reduce the costs of health care (Ashton and Seymour 1988), it also appears that the traditional approach to health care was, at this time, becoming increasingly criticised in terms of its capacity to reduce the incidence of disease and increase well being.

McKeown ( 1979 cited in Scrambler 1991) demonstrated convincingly in his research how the decline of infectious diseases, such as tuberculosis, over the previous century was more a consequence of improved social conditions than a result of the medical intervention of immunisation. This understanding of the social determinants of health had been recognised by the WHO as early as 1946 ( Tones and Tilford 1994) but McKeown concluded that traditional health care agencies ignored the impact of social factors on health status. More recent research has increasingly supported this view. The Black Report (1980), the Health Divide (1987 both cited in Townsend and Davidson 1988) and Davey et al (1990) have continued to provide convincing evidence that there are differences in health status according to social circumstances while Graham (1984) argues that the 'clustering' of unhealthy behaviours are symptomatic of poor social circumstances. The findings in the previous chapter that women in Social Classes 4 and 5 are less likely to breastfeed reflects the main message of these documents in that 'there is a strong correlation between material/ social circumstances and the experience of health and illness' (Thorogood 1993 p51) with women in the lower social groups adopting the least healthy lifestyle. The recognition that social factors have a similar impact on other health behaviour, gives further support to the influence of social factors in determining breastfeeding patterns.

Also during the 1970s the health education document, 'Prevention and health - everybody's business' (1976), produced by the Government, encouraged the view that

decisions in health were a consequence of individual choice, based on lifestyle. This document encouraged people to believe that a more healthy lifestyle could be adopted if people were given appropriate information. Thus, acquiring knowledge about the value of breastfeeding, might ensure that more women would adopt the practice. As MacIntosh (1985) has demonstrated this does not happen. As already discussed, the fact that information is frequently inaccurate and often conflicting (Garforth and Garcia 1989), may well be one reason why the traditional approach to health education is unsuccessful, but perhaps more significantly, the influence of social circumstances has been ignored. The evidence in the previous chapter, citing lack of time, returning to work and peer group pressure as key factors in the practise of breastfeeding, implies that individuals are frequently unable to make a 'free choice'. Therefore any strategy which relies solely on the provision of information without addressing other pertinent issues is unlikely to be effective and may well result in the 'victim' being blamed for continuing with a less healthy behaviour (Naidoo 1986 cited in Rodwell and Watt 1986).

Recognition of the relevance of social circumstances to health behaviour, and increased appreciation of the limitations of the traditional health education approach, occurred at a time when additionally medical personnel were becoming increasingly criticised. The dominance of the medical profession according to Illich (1977 cited in Seedhouse 1986) created passivity and reduced autonomy in the individual, while Oakley (1986 cited in Miles 1991) contests that women are oppressed by the patriarchal attitude of medical practitioners particularly during and around childbirth. In response to both of these criticisms, the NCT, established in 1956, dramatically increased its membership during the 1970s, with women requesting that health professionals should treat them as individuals, with a right to make their own decisions (Kitzinger 1990).

Williams (1989) considers that women, as well as being oppressed by the medical profession, are also oppressed as a result of both their gender and social class. Hence women in the lower social classes are less likely to breastfeed not only because of their class status but also as a result of further inequality within that social group between the genders. Van Esternik (1989) perhaps best illustrates this point by citing a study by Brack (1979) which demonstrated that breastfeeding decreased when a women's social power decreased relative to the men in their own group, a tendency which appears to apply most particularly to those women in the lower social class groups. The influence of the woman's partner (LeFevre 1987) in determining infant feeding patterns is perhaps now more understandable, while speculation in the previous chapter that the barriers which constrained women were greater for those in the lower social groups is confirmed. That work for middle class women proves less of a barrier to breastfeeding is easier to understand (Birenbaum1989), while the fact that the NCT has middle class origins is perhaps to be expected, given that these women, experiencing less oppression, would be more able to express their dissatisfaction. (Kitzinger1990).

Oppression therefore appears to have an important influence on a woman's health status, due to her position in society in general and her relationship with health professionals in particular. Furthermore Friere (1985 cited by Carley 1990) suggests that domination occurs when power, technology and ideology come together and oppress the silent majority. In this broader analysis not only do the effects of patriarchy influence women in their 'choice' over infant feeding issues, the effects of consumerism can also be included as the technology that provides infant formula is dependent on consumerism for its development. Carley (1990) would concur suggesting that as oppression is all pervasive it can be used as an analytical tool. Having identified areas of oppression, strategies to minimise its impact are needed if health promotion is to be influential.

With oppression identified as a 'key factor', strategies which empower women are needed. Health promotion is about enabling choice. Given the complex social barriers to breastfeeding activity it can be postulated that necessary action requires a multi-faceted and multi-disciplinary approach, involving action from individuals/groups other than health professionals alone. Friere (1972 cited in Hunt 1990) suggests that empowering strategies require individuals both to define their own needs and implement their own solutions, which Ewles and Simnett (1995) suggest will bring about behavioural change and have the additional benefit of increasing self esteem. The idea that individuals can take control of the issues that are important to them provides a contrasting approach to the traditional form of health education which relied on health professionals 'being in charge'. With individuals and groups setting the agenda, a change of role for the health promoter is indicated.

Nevertheless, the argument that removing the social barriers that impact on women's health behaviour and increasing personal control will result in a healthier lifestyle cannot be assumed. As Patterson (1982 cited by Thorogood 1993) suggests, choices are often influenced by 'lay beliefs', many of which are embedded in society, and there is no reason to suggest that these views will change. This concurs with the evidence of Hewat and Ellis (1986) who suggested women frequently preferred information about infant feeding issues based on personal experience rather than research based evidence. Evidence earlier also revealed that while some women find breastfeeding a very satisfying experience (Locklin and Naber 1993) other women prefer to know how much milk a baby is drinking (Soo et al 1987). This suggests that some women will feel empowered by breastfeeding while others may feel empowered when bottle feeding. In consequence, enabling choice may not necessarily effect a change in the number of women who breastfeed.

Such strategies may therefore be problematic for the health promoter given there are targets to achieve. Setting a breastfeeding target of 75% (Smith and Jacobsen 1989)

appears inconsistent with the underpinning principle of empowerment. Nevertheless, by advocating the use of targets, the WHO appears to assume that breastfeeding and empowerment are mutually achievable. Hunt (1990) argues that if health promotion is truly self or group directed it is impossible to have targets. Suggesting the number of women who breastfeed should increase by a predetermined date is inappropriate. He agrees with Helsing and Saadel (1991) who consider that, for women, empowerment should enable them to gain control, giving them confidence to succeed in their role or activity irrespective of whether they choose to breastfeed. An increase in the number of breastfeeding women would not necessarily indicate empowering strategies had been employed, indeed a coercive approach on the part of health professional to 'encourage' a women to breastfeed would suggest the reverse. This raises two important issues. How can the potential of health promotion to effect change be measured if breastfeeding targets will not necessarily demonstrate empowerment? Who will benefit from target setting?

Examining the development of the current framework for health promotion reveals that a growing awareness of the limitations of traditional health education has occurred in conjunction with a better understanding of the determinants of health. Both the societal barriers and the role of the health professional have been criticised as being oppressive, particularly for women and especially for those women in the lower social groups. The barriers within society that impact on the practice of breastfeeding limit the freedom to choose, while inappropriate health professional support is similarly disabling. It is to be expected that the strategies embodied in the Ottawa Charter (1986) reflect this understanding. To evaluate at a theoretical level whether health promotion is able to offer a way forward it is therefore necessary to examine the strategies proposed in the Ottawa Charter (1986). This will identify whether this current theoretical framework for health promotion has strategies to address the issue of oppression and the factors that specifically relate to the activity of breastfeeding.

### **A review of the strategies proposed in the Ottawa Charter (1986).**

Preceded by the Lalonde Report of Canada (1974) the Ottawa Charter (1986) is not the first report to offer a conceptual framework for health promotion. This earlier report also emphasised the need to look at public health issues, having recognised the importance of the social context of health behaviour. The Ottawa Charter (1986), therefore should be seen as a further development in the process to offer appropriate strategies for health promotion.

In the opening statement of the Ottawa Charter (1986) health promotion is defined as a process of enabling people to increase control over their lives. This demonstrates that empowerment, both of individuals and groups, is the key issue. Discussed further, health promotion action is identified as enabling all people to achieve their health potential by removing the barriers which can impact on health, addressing the issue of equity, allowing individuals and groups to make an informed choice and giving appropriate support. It suggests that people must be able to take control of the issues that determine their health. Clearly addressing the issue of empowerment is seen as the most effective way of ensuring women will be able to practise breastfeeding if they themselves so choose.

The first strategies that the Ottawa Charter (1986) considers imperative are those of building healthy public policy to create a more supportive environment. This should allow, according to Milio (1986), the healthier choice to become the easier choice. The Charter stresses that a socio-ecological approach to health is necessary, with all sectors and all levels of society taking responsibility for health issues. As such, the Ottawa Charter (1986) states that the responsibility of creating a supporting



environment requires legislation, fiscal measures, possible taxation and organisational change.

Clearly the way society is currently organised, in terms of class and gender structure, is a potential barrier to encouraging a healthy lifestyle in general and breastfeeding in particular. Bunten (1992) suggests health promotion action needs to be involved with manipulating the environment by using social policies to create a society where health is the key issue for all planners and policy makers. This raises the issue of infant formula, both of its production and distribution, as well as the social factors that impact on the decision to breastfeed. As such, this strategy has taken into account the recent evidence collated by studies such as the Black Report (1980 cited in Townsend and Davidson 1988) and is looking beyond the traditional health service for action to effect change. Political, multi-sectoral and multi-level support is seen as essential.

In theory it appears that developing public health initiatives could have an influence on the barriers that impact on health behaviours such as breastfeeding. As the activity of breastfeeding is influenced by the constraints of maternity leave, (Winikell and Baer 1980 cited in Carbello and Peltó 1991) then legislation to address the issue may enable more women to breastfeed. According to Green and Raeburn (1988) taking those decisions, if they are to empower effectively, would require public consultation and planning before any decisions were taken. They postulate that the impracticality of implementing such action, could lead to an approach based too heavily on policy, with the experts planning for the people. In consequence, a potentially totalitarian approach may well meet with non compliance. This suggests that while there are public health issues relating to the activity of breastfeeding, putting theory into practice appears complex.

In conjunction with the need for healthy public policy to create a more supportive environment the Ottawa Charter (1986) also advocates strategies to strengthen

community action and develop personal skills. Community action is seen as a community or group taking control of its own destiny by drawing on its own resources, defining its own needs and creating strategies to achieve its own objectives. Support from external bodies is necessary, with access to information and funding as essential, if health status is to be improved. Whitehead (1991) would concur, as she considers that inadequate access to health care provision and provision of less resources to those with the greatest need is both inequitable and unacceptable. This was illustrated by Sharma (1994) when she demonstrated how the Vietnamese women were further disadvantaged by the additional problem of the language barrier.

Developing personal skills has a similar purpose, but addresses the needs of the individual. Again the Charter emphasises the need for the individual to take control and make choices that will be conducive to good health, with support being provided by educational, commercial and voluntary bodies. The principle issue of empowerment, at a local level, is again a central theme. The earlier criticism of the patriarchal nature of traditional health care and the limitations of traditional health education (Naidoo 1986 cited in Rodwell and Watt 1986) has led to a recommendation that the individual should work in partnership with agencies who can both inform and support health care initiatives. As such, in theory, the current framework for health promotion has distanced itself from its traditional roots (Green and Raeburn 1988) not only by suggesting that health professionals need to approach clients as equal partners but also by recognising that health promotion activity will be more effective when there is a multi-disciplinary approach.

While Green and Raeburn (1988) questioned the potential for empowerment through healthy public policy they feel confident that community participation has the ability to offer enabling strategies. They suggest that the emphasis on self help groups and community projects would allow power to be devolved to the community. This suggests that the National Childbirth Trust, known for its support of breastfeeding

women (Durwood and Evans 1990), may well be seen as a more appropriate source of advice and support, working either independently within the community or in partnership with health professionals.

The health promoter needs to work in a different way. The necessary skills involve those of advocate, mediator and supporter to develop a partnership style relationship with the client. The hierarchical relationship, between the professional and client is of no further use. Elaborating on the concept of partnership Downie et al (1990) suggest that empathy, achieved through a non-judgemental approach, would enable the health professional to recognise the constraints that limit choice. Ewles and Simnett (1995) consider empowerment through partnership permits the community or individual to arrive at their own decisions, thus allowing people to modify the way they feel about themselves, and as such, think more critically about their own values and beliefs. Weare (1992) suggests it has long been recognised that people need to learn skills to enable them to take charge of their own lives, but, as Bennett and Hodgson (1992) suggest the traditional approach to health education where individuals are 'talked at' is no longer appropriate.

Implementing strategies which empower is unlikely to be easy. As Green and Raeburn (1988) suggest those who have power may be reluctant to give it up, while Rissel (1994) considers for one group to empower another group can in turn disempower the initial group. He elaborates by citing Swift and Levin (1987 cited in Rissel 1994) who suggest that empowerment can be achieved at an individual level without either participant being disempowered, but considers it impossible at societal level due to the nature of western capitalist culture. Seedhouse (1986) meanwhile suggests that even at an individual level empowerment may be extremely difficult. He considers that some individuals may have too few personal resources, while Townsend and Davidson (1988) similarly suggest that some social groups have considerably fewer resources and may therefore have difficulty achieving their aims. This suggests it may be more

difficult to empower those women who are currently least likely to breastfeed, for example, women who are anxious and lacking in confidence (Soo et al 1988), or those who are within the lower social groups.

The Ottawa Charter (1986) advocates strategies that are designed to empower. Women should be enabled and have the confidence to make an 'informed choice'. Healthy public policy to address the social circumstances that appear to influence breastfeeding practice is recommended. Rejecting the traditional approach to health education by proposing that health promoters work in a fundamentally different way, reflects the evidence of Oakley (1986 cited in Miles 1991) and Buckell and Thompson (1995), both of whom reported women were dissatisfied with the advice and support they received. Clearly the Ottawa Charter (1986) has addressed the factors, identified in this dissertation, which impact on the decision to breastfeed, providing strategies which reflect a better understanding of the real influences on health behaviour. In theory health promotion appears to offer a way forward, but the complex nature of health behaviour and health promotion cannot be ignored. Furthermore translating theory into practice may not be easy. The preface to the Ottawa Charter (1986) which links health promotion with target setting describes an incongruity which may provide an area of tension for any health promotion activity, as women may not be empowered necessarily by breastfeeding. To explore this question further, and to identify whether health promoters can empower women by working in this newly defined way, analysis is required of the work that is currently carried out in the name of health promotion relating to breastfeeding.

## **Chapter 5- Is current health promotion activity creating a more supportive environment for breastfeeding?**

Research evidence has clearly demonstrated that the social position of women within society (Williams 1989), the constraints of work (Escriba et al 1994), demands on a woman's time (Levine 1988) and the availability of breast-milk substitutes (Carbello and Pelto 1991) influence the activity of breastfeeding. Women also consider that the difficulty or embarrassment of feeding in public is a barrier (Mc Intosh 1986). The Ottawa Charter (1986) suggests healthy public policy is required to minimise the impact of such social factors by creating a more supportive environment. (Ashton and Seymour 1988). It proposes legislation or informal agreement will be needed, using a multi-disciplinary and multi-level approach, to remove the barriers that constrain individuals from making a healthy choice. The purpose of this chapter is to examine critically public health initiatives directed towards creating a more supportive environment for breastfeeding women. The analysis will consider the extent to which health promotion in practice is underpinned by the key principle of empowerment, together with the extent to which the initiatives create, in reality, a supportive environment for those women who wish to breastfeed.

### **The public health initiatives advocated by the WHO/UNICEF to create a more supportive environment for the practice of breastfeeding.**

For many years the WHO/UNICEF have been committed to removing the barriers that impact on the practice of breastfeeding through healthy public policy. In 1981 they promoted the International Code of Marketing Breast Milk Substitutes in an attempt to encourage the milk manufacturers to take a more responsible approach to the impact of their products. Even at this early date the social influences that impacted on breastfeeding practice were acknowledged with a call to address the issue of social injustice (Morrow and Barraclough 1993). Since then the Innocenti Declaration

produced by the WHO/UNICEF (1990) reflects the decisions of a conference 'Breastfeeding in the 1990s: a Global Initiative'. It recommends that healthy public policy is required at all levels to remove the barriers in society that impact on the practice of breastfeeding. Removing obstacles within the work-place to protect the rights of the working women is given particular emphasis, while both community and 'health systems' are identified as important areas for 'action'. The importance of establishing targets for breastfeeding uptake is also advocated, with areas of excellence being identified and the prevalence of breastfeeding women at 4 months being recorded. Clearly, with the exception of the tension between empowerment and breastfeeding targets the call for healthy public policy reflects contemporary thinking in health promotion. This poses the question as to how governments and other agencies have responded.

### **Has healthy public policy reduced the social barriers which impact on the practice of breastfeeding?**

As social inequality influences health behaviour generally, policies to address this issue will be considered first. The findings of the Black Report (1980) which advocated action to alleviate poverty as a way of ensuring social equality were rejected by the Government (Townsend and Davidson 1988) on the grounds of expense. That is not however the sole reason. The current government, although it sees individual responsibility and choice as important, subscribes to the view that the freedom to choose is constrained by lack of knowledge as opposed to social constraints. Social policy to change the structure of society is therefore seen as both unnecessary and undesirable (Benzeval and Judge 1990), as allowing market forces more freedom will encourage individuals to achieve both wealth and status by their own efforts (Hart 1991). Thus, it is the responsibility of the individual to determine a change in behaviour. Clearly the current government's philosophy is similar to that of traditional health education, they are unconvinced by the structural/materialist

explanation of health behaviour (Nettleton and Bunten 1995). From a political perspective there are other practical considerations which appear to impact on health promotion initiatives. As Parish (1995) states the time scale for achieving such health promotion targets exceeds the lifetime of most governments and as such are politically unattractive. Equally it must be recognised, particularly in a western capitalist society, that change frequently involves conflict between different interested parties. 'The potential for conflicts of interest, such as a perceived reduction in income tax and possible unemployment' (Parish p19) makes the issue one of great complexity. When there is no compulsion to act it is easier to maintain the status quo.

Evidence of public policies, implemented by governments which have adopted a more structuralist approach, can be found in Sweden, a country which has been more committed to eliminating class differences. Ginsberg (1993) states that inequality is, however, still an issue, particularly for women. Mainly employed in the public sector, women earn 80% of an equivalent full time salary while 46.4% of them are employed part time. While evidence suggests class differences have been minimised, gender still impacts on a woman's level of affluence. Comparing Britain with Sweden, statistics show that 93% of women initiate breastfeeding in Sweden (Ginsberg 1993) against 63% in Britain (White et al 1992). This does suggest that less class division and greater parity of income may influence the pattern of breastfeeding, although to place too much emphasis on this one issue would be naive given the complexity of the issues surrounding infant feeding. However, the recent decline in number of women who breastfeed in Sheffield (Emery et al 1990), an area affected by the recent recession, may well be a consequence of the greater social inequality that has occurred over the previous decade (Whitehead 1987 cited in Townsend and Davidson 1988) as well as the reduction in medical support (which Emery considered was the sole explanation).

The WHO/UNICEF (1990) considered that the needs of working women were of particular importance. This raises the issue of government policy and maternity leave.

Sweden provides 15 months paid parental leave (Moss1996). At any one time 20% of the female workforce are on parental leave (Ginsberg 1993). This is a marked contrast to Ireland with only 14 weeks of maternity leave where only 29% of women initiate breastfeeding (Becker 1993). However, while 93% initiate breastfeeding in Sweden, by 6 months only 19% (Ginsberg 1993) have continued against 21% in Britain (White et al 1992). The contrast between the Swedish and Irish experience suggests that the length of maternity leave encourages women to breastfeed. The reduction in the number of breastfeeding women at 6 months perhaps indicates more that generous maternity leave and greater equity has been empowering by enabling choice, rather than achieving a prolonged period of breastfeeding, illustrating the difficulty of target setting as a measurement tool for health promotion.

Maternity leave aside, creating a more supportive environment in the work-place and community does not appear to be viewed as a political issue in this country. As such there are no legislative rights for a woman both to work and breastfeed. In contrast, working women in Norway are allowed up to 2 hours per day without loss of pay to breastfeed, which, according to Jones and Narayan (1995) means very few babies are bottle fed. With many women in the UK returning to work day-care facilities in the work place are essential if women wish to continue breastfeeding. The WHO/ UNICEF (1989 cited in Spiro 1989) has called upon the traditional health services to be a good role model by providing local facilities and flexible working schemes.

Locally there are two hospitals serving a population of 330,000 inhabitants. Both hospitals have day care provision on site, the second one being opened in 1995. Not all the children cared for necessarily have mothers who work on the site, but of those who do, most of the babies are bottle fed (personal communication with the nursery manager 1996). She reported that over the previous 6 months, three women had continued breastfeeding, with the mothers visiting the nursery every lunch time. Children are usually around 3-4 months of age when women return to work at the



hospital and as partially weaned, other mothers may have thought it more practical to give the baby a bottle when returning to work. Meanwhile the current hospital policy allowing women to take a year's leave following childbirth makes it difficult to assess whether the provision of a day nursery does make it easier for women to breastfeed, as those women who are remaining at home may be staying at home to breastfeed.

The provision of work-placed day-care does appear to be able to create a more supportive environment for breastfeeding, but the idea that provision on a hospital site will necessarily encourage other work-places to follow their example is perhaps naive. In the local area there is only one other work-placed day nursery. Lisle (1991) suggests that there are changing patterns of work for men and women with less job security. Both flexible and part time work are becoming more common resulting in work places having less reason to develop systems that benefit the workforce. Also childcare is both costly to provide and costly for parents to access, with many women finding it too expensive (Leonard and Speakman 1986). The lack of compulsion or incentive to establish work-place day-care, and the lack of co-ordinated healthy public policy at a political level, means that any action to create a more supportive environment will be both fragmented and limited. Health does not appear to be key issue for employers as it would be if practice reflected the recommendations of the Ottawa Charter 1986 (Bunten 1992).

The difficulty of breastfeeding in public was demonstrated by the Joint Breastfeeding Survey (1990 cited in Entwistle 1991) which revealed that 40% of people felt breastfeeding in public was wrong and over 50% would not like a baby breast-fed in a restaurant. The supermarket chain Sainsburys, in Nov 1995, stated that an area in each of its coffee shops would be set aside for women who wished to breastfeed. This change of policy can perhaps best be compared to the public led health initiatives which have made many public areas no smoking zones. As Bunten (1992) describes, the developing of public no smoking areas has been achieved through public demand

for change. It required collaborative processes involving the participation of groups and members of the public who felt strongly about the effects of passive smoking. Similarly, women who wish to breastfeed in public (The Campaign for the Rights of Breastfeeding women) have campaigned and achieved a policy change that is appropriate to their needs.

While it is too soon to evaluate the effectiveness of Sainsbury's policy it is perhaps appropriate to highlight the differences between the policy initiatives which serve to remove the barriers that impact on the practice of smoking and breastfeeding. Social policy to stop smoking in public places is a response to a large sector of the population who are fearful for their health, in contrast to a much smaller group of women demanding the right to behave in a way they feel is appropriate. As such, the success of the latter group perhaps cannot so easily be assured, particularly as the underlying reason for the public's aversion to breastfeeding is considered to be deeply embedded in western culture (Van Esternik 1989). Logically, empowering strategies will be easier to achieve through social policy when larger numbers of people are demanding action, particularly when those who are innocent of bad practice are being exposed to a known health risk. In this discussion while social policy can be empowering for women who breastfeed and non smokers, it does illustrate that social policy may not necessarily empower everyone, smokers, for example, may feel disempowered by the restrictions that have been placed on them.

The WHO (1990) has accurately indicated the areas where healthy public policy may achieve a more supportive environment for the practice of breastfeeding but all too frequently the recommendations are ignored or conceptualised inappropriately (Morrow and Barraclough 1993). They illustrate this point by describing the situation in Australia where breastfeeding is seen as a nutritional issue dealt with by the DoH. Similarly in Britain the Joint Breast Feeding Initiative established in 1988 had a remit to introduce policies to promote breastfeeding (Poskitt 1992). It has merely

recommended that health promotion activity is initiated at local level. In 1995 the DoH announced that each region would have breast-feeding co-ordinators at regional level, while guidance policies have been written for purchasers and trusts to make the NHS 'more breastfeeding friendly' (Anderson 1995). As in Australia these initiatives, although labelled as health promotion, do not have empowerment as their principle goal and are not addressing all the issues that impact on the practice of breastfeeding. With the emphasis they place on education and the role of the health service to effect change, they are reflecting practice more associated with the traditional form of health education and health care (Morrow and Barraclough 1993).

In conclusion, from this analysis, with the exception of the evidence in Norway where working women have been enabled to breastfeed, there appears to be little evidence of healthy public policy to remove the social barriers that impact on breastfeeding behaviour. The strategies proposed in the Ottawa Charter are, in the main, either contested or ignored. Collaboration between agencies to develop an intersectoral approach is not being achieved, while lastly, and most importantly, the strategies that are being implemented do not address the issue of empowerment which is central to the current conceptual framework for health promotion.

### **Can healthy public policy meet the challenge created by the availability of infant formula?**

The availability of infant formula has been shown to have an impact on the practice of breastfeeding (Carbello and Pelto 1991). The 'Innocenti declaration' (WHO 1990) recommended that action is still needed to implement the principles and aims of the articles of the 'International code of marketing of breast milk substitutes' (1981) which advocated policies to alter both the distribution and advertising of infant formula products. The International Association of Food Manufacturers has published its own

document to 'assure the appropriate use and marketing of infant feeding products' (IFM1991 p.5).

Reviewing the impact of the 1981 code of practice Palmer (1993) reveals the difficulty of implementing a voluntary code when there are other vested interests for the persons concerned. She describes how over the years voluntarily agreed codes have been ignored or circumvented. Potrykus (1989) reports how free samples were still being distributed to hospitals 3 years after the WHO passed a further resolution on this issue in 1986. UNICEF (1995) reports that progress is now 'encouraging' as 72 of the developed countries banned the practice in September 1994. Perhaps they are correct to be cautious as, faced with the ban of providing free and subsidised milk to hospitals in the UK from Jan 1990, milk firms adopted similar practices to those they employ in the third world, delivering the goods and failing to remind hospitals that payment was due, thus effectively continuing their free supplies (Jackson 1993). Palmer (1993a) also criticised the RCM for allowing Farley's a promotional stand at a lecture she was giving on breastfeeding, as it continued the link between manufacturer and medicine which has helped to promote infant formula since 1924 (Campen 1993).

The 1995 Infant Formula and Follow On regulations have been introduced three years after the European Union had again sought to ban all infant formula advertising to the public. Erlichen (1995) describes how the regulations when finally published were a watered down version of first draft (which had complied with the European recommendations), allowing the milk manufacturers to continue advertising. This has resulted in Bounty, who have traditionally always provided a free pack of 'goodies' on leaving hospital, paying hospitals 80p for the name and address of each woman expecting a baby so the packs of 'educational material' and free samples can be sent to the home (Jones and Narayin 1995).

Baby Milk Action, in its news letter ( Sept 95) has requested that any observed promotion of infant formula should be reported to trading standards officials as this may contravene the new UK marketing law. As Erlichen (1995) reports, the spokesperson for Baby Milk Action considers the avoidance of an outright ban on advertising will increase the baby milk market, while the Infant and Dietetics Foods Association (representing the milk manufacturers) considers their information service, in conjunction with the availability of their product, increases choice for women. Both parties have their own goal which determines how they perceive empowerment. Given this situation, it is perhaps to be expected the milk manufacturers, being a more powerful organisation (with their annual turnover in Britain of £119 million) are more likely to be successful than an activist group with little influence, particularly when the Government does not necessarily view social policy as a effective way of creating a healthier environment.

Offering a viable alternative product does increase choice for women but milk companies could be accused of disempowering women if they produce advertising material that is biased and inaccurate. Robins (1993) reports that milk manufacturers spend £12 million promoting their product against the Government's investment of £50,000 to promote breastfeeding, suggesting it must be to the milk manufacturers' advantage. He considers that this money is spent not just on general advertising but subtly promotes a bottle feeding culture that implies bottle feeding is actually better for the baby. For example, Farley's milk is advertised with a picture of a contented sleeping baby with the words 'Andrew Walker expresses his unreserved satisfaction with Farley's milk' which then is described as being 'scientifically designed to provide all the right vitamins and minerals for healthy growth' (Jones and Narayan 1995 p5). Given the evidence in Chapter 1, this claim, which is both exaggerated and inaccurate, does not aim to empower women by allowing them to make an 'informed choice', as its sole purpose is to sell the product.

Whether legislation or voluntary agreement is more capable of creating a more supportive environment is debatable. Palmer (1993) describes how attempting to legally enforce public policy in Peru proved too difficult to implement. While the legislative ban on advertising in Norway cited as one of the reasons for the high rate of breastfeeding (Erlichen 1995), could be criticised for disempowering those women who may wish to bottle feed. Whether Norwegian women feel empowered by breastfeeding would need further research, but it would be interesting to know if the same women were asked their views about advertising prior to the ban being put in place, a necessary requirement of any action if it is to be empowering in its execution (Green and Raeburn 1988). In the UK, the milk industry, because it has for the most part been left to regulate itself, has shown little commitment to reducing the impact of its product. Sai (1991) considers economic difficulties must inevitably inhibit any action that is seen to undermine industrial expansion, showing that when there is a conflict of interest financial considerations take precedence over health issues. He concludes that industry must be seen as a partner to scientists, physicians and the population at large; collaboration is essential. This later observation is consistent with the philosophy of the Ottawa Charter (1986) but there does not appear to be any real commitment from the milk manufacturers in the UK to comply.

This analysis has shown that social policy, as demonstrated in Norway, can significantly increase the number of women who breastfeed, although the difficulty of identifying the extent such action has empowered women is impossible to determine since empowerment itself has not been measured. In the UK, there is no evidence that a more supportive environment for the practice of breastfeeding has been created over the past 10 years. The recommendations put forward by the WHO reflect accurately the current concept of health promotion but there is an unwillingness in practice to make health a central issue of all policy making. Evidence has indicated that different groups are likely to interpret empowerment in different ways and further evidence that social policy may empower one group at the expense of another. For the most part

recommendations are ignored, or implemented so reluctantly and slowly, a lack of commitment to the issue of empowerment is demonstrated. Issues when addressed, are frequently interpreted in a way more associated with the traditional approach to health education while the principles and beliefs that underpin the current concept appear to be contested. In particular the current Government's rejection of the ideology encompassed in the WHO/Ottawa Charter framework of health promotion has impacted greatly on healthy public policy initiatives in this country. In conclusion therefore, very little action relating to the practice of breastfeeding has been identified that is either empowering in its execution or effect.

## **Chapter 6 - Does current breastfeeding health promotion activity empower women by encouraging community participation and developing personal skills?**

Whilst social factors and availability of infant formula appear to provide barriers to breastfeeding activity, evidence also suggests that the support and advice women receive during their pregnancy and in the early weeks following delivery have an impact on the practice of breastfeeding. The medical profession has been criticised for being inconsistent in both its advice and support (Rajan 1993), while the practice of offering supplements to a breast-fed baby, a restricted feeding regime and early separation of mother and baby, are highlighted as particular areas of concern (Garforth and Garcia 1989). According to the Ottawa Charter (1986), appropriate health promotion activity to facilitate the necessary support for women who breastfeed would be achieved by encouraging community participation and developing personal skills, with empowerment as the principle goal. The purpose of this chapter is to examine critically current health promotion initiatives that provide support and advice to pregnant and nursing women. The analysis will consider the extent to which this practice is empowering, both in its implementation and its effect.

### **The 'Baby Friendly Initiative' (WHO/UNICEF. 1991).**

The WHO/UNICEF (1991) has responded to the criticism of health care provision by launching its 'Baby Friendly Initiative'. It recommends that 10 issues need to be addressed.

- o Have a written breastfeeding policy that is routinely communicated to all health care staff.
- o Train all staff in skills necessary to implement this policy.
- o Inform all women about the benefits and management of breastfeeding.
- o Help women initiate breastfeeding within an hour of birth.
- o Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.



- o Give newborn infants no food or drink other than breast milk unless *medically* indicated.
- o Practice 'rooming in' - allow mother and infant to remain together 24 hours a day.
- o Encourage breastfeeding on demand
- o Give no artificial teats or pacifiers to breastfeeding infants.
- o Foster the establishing of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.' (WHO/UNICEF 1991).

Hospitals complying with these recommendations and having 75% of their clients initiating breastfeeding can then be awarded 'Baby Friendly Status'. The UK Baby Friendly Initiative was formally recognised by the DoH in 1993. While the original aim was to raise standards of hospital care, the UK initiative has been extended to include those professionals who work in the community, a sensible approach as babies can be discharged home as little as 6 hours after delivery. The WHO/UNICEF (1995) currently reports that over 1000 hospitals globally display the Baby Friendly Plaque while another 14,000 hospitals are in the process of changing their standard procedures. In Sweden 41 of the 61 hospitals in the country had been designated 'Baby Friendly' by the middle of 1994, while the UK currently has two.

Clearly the WHO/UNICEF have based their recommendations on the current scientific evidence for successful breastfeeding. Nevertheless the prescriptive nature of the document, more indicative of an authoritarian approach, does not assist the health professional to develop a partnership style relationship with the client. In particular, the forbidding of pacifiers, or the supplementation of breast milk and rooming in the recommendations are expecting compliance from the breastfeeding woman, which may leave the woman unable to make appropriate decisions for herself. This illustrates, Downie and Calman's (1987) observation, that a paternalistic approach is neither ethical, nor conducive to empowerment, with women leaving hospital dependent on the prescriptive advice of the health professional, rather than feeling confident in their own ability.

Gaining 'Baby Friendly' status, while enhancing the status of the hospital, would not necessarily indicate that health promotion activity was empowering. Indeed the WHO/UNICEF, by using a prescriptive approach, could be encouraging the health professional to adopt a coercive, as opposed to empowering approach, as it has benefits for the organisation in which they work. It is therefore surprising that the WHO, the organisation seen as the 'mouth piece' for health promotion, is advocating measures which appear to make health promotion more difficult to implement in an empowering way.

### **Is current health promotion providing appropriate support and advice for women?**

Given that women have been asking for consistent advice (Garcia and Garforth 1989) a breastfeeding policy should ensure a more coherent approach to the practice of breastfeeding. Implementing such a policy in response to client demand complies with the ethos of the Ottawa Charter (1986), while the provision of a local breastfeeding policy means that individual authorities can respond more directly to local needs, making community participation possible through a multi-disciplinary approach. Locally, the infant feeding policy was launched in 1992. The working party consisted of hospital and community based staff as well as representatives from the NCT. Following the publication of the document in-service training was given to staff. In the community this involved all health visitors with an additional teaching qualification cascading the information to other health visitors, clinic nurses, nursery nurses and clinical medical officers.

Evans (1995) describes the introduction of the Infant Feeding Policy in Derbyshire in 1993. Similar problems to those experienced locally were identified. Writing the document was relatively straight forward but getting the document accepted by those professionals not involved in drafting the policy was more difficult. Locally the training

sessions did not include all the relevant disciplines as GPs were omitted. Evidence in Fife also revealed that medical staff were not as conversant with the contents of the infant feeding policy as other health professionals (Campbell et al 1995). Generally it appears that only 10% of paediatricians receive training about breastfeeding (Michaelman 1990 cited in Campen 1993). The reluctance to involve the medical profession in the cascading of the infant feeding policy must undermine the effectiveness of the document, while Evans (1995) reflects on the difficulty of continually updating both policy and staff during the current period of financial restraint which many health authorities face.

The complexity of the information and the number of health promoters involved makes evaluating any improvement in support and advice very difficult. As the particular recommendations of the WHO/UNICEF (1991) have to be incorporated into the policy document, if a hospital wants to acquire 'Baby Friendly Status' it is possible to evaluate these particular issues. Evidence from hospitals in Fife (Campbell et al 1995) revealed that not all members of staff were conversant with the policy. Babies were put to the breast as soon as possible and mothers were given extra assistance to breastfeed, with 8 out of the nine having been shown the correct positioning for the baby. However, 6 out of 9 babies were given complementary feeds, while 4 out of 9 had been advised to restrict the feeding time. Using the WHO's recommendations as a tool for audit reveals that the advice and support women receive remains inconsistent. This method of research is also unable to demonstrate whether women feel empowered. Out of 21 mothers, 9 women reported that the baby had not been with them during the night, which does not comply with the 'rooming in' recommendation. However there is no indication as to whether the women had been unhappy with this situation or had even requested that the baby should spend the night in the nursery. Perhaps measurement of maternal satisfaction may be a more appropriate indicator of empowerment. Such information in conjunction with the above research findings in Fife would provide a better understanding of current health promotion activity in Fife.

Buckell and Thompson (1995) demonstrate that maternal satisfaction can be related to an increased number of women who breastfeed. In Hillingdon, over a 3 year period, there was a 4% rise in the number of women who breast-fed with an 11% increase in the satisfaction rating for the support offered by health visitors and community midwives. The factors that have contributed to this change are identified as the introduction of team midwives, where the mother knew the midwife who would deliver her, improved liaison between midwives and health visitors, and extra support given to those women who breast-fed. Such strategies, having addressed the issues that women have raised, are seen as more appropriate by the client group and have had the additional benefit of increasing the breastfeeding rate, which as Locklin and Naber (1995) report can be an empowering experience for women.

Facilitating supportive networks through community participation is an alternative and acceptable approach. Directed by women themselves and serving the local community, the NCT has developed a strong local base providing an information service and supportive network for all its members. As such, those women involved in the organisation and delivery of the services may well consider they are empowered, but the ability of such an organisation to empower all women is questionable. Kitzinger (1990) suggests that the NCT of the 1980s 'espouses the 'right to choose' in a way that it never did in the beginning.' (p.109). She describes how in its early days the organisation, although it inferred women had the right to choose, like the medical profession it took the view that most women did not know what was best for them. Now the woman's right to make her own decisions is central to the trusts campaigns. Yet even when empowerment is accepted as the 'key principle' strategies that achieve this goal may be difficult to implement. Locally the NCT is always involved with the annual 'Breastfeeding Promotion Week' and visits local schools to raise awareness about breastfeeding. By promoting breastfeeding, the NCT demonstrates how one group of women can further disempower another group of women (Rissel 1994), as

some women who receive such advice may feel compelled to comply or alternatively feel guilty because they bottle feed.

A local midwifery manager (March 1996) reports that liaison between the NCT and midwives occurs at a Breastfeeding Forum when health promotion activity is discussed. Two breastfeeding counsellors from the NCT (who are also midwives) are available on the wards, to provide a link between hospital and home. The support system is reported to work well. The previous NCT counsellor, who was not a registered midwife, met with resistance from members of the staff. There is no indication as to whether local women feel satisfied with the support they receive, which would be a better indicator of whether current strategies were empowering, but it does suggest that health professionals, defensive of their role, are unwilling to form the inter-agency partnerships that current health promotion advocates. This concurs with evidence of Beeton and Waterson (1992) who although reporting that 71% of health professionals felt supportive lay agencies should be better advertised, found that less than 45% felt they should be allowed in hospital. Almost all of those who felt that support should be initiated in the hospital worked in the community. .

It was suggested by Townsend and Davidson (1988) that creating supportive networks would be more difficult in areas of greater deprivation. This does appear to be the case, as the NCT is far less successful in working class areas (Ineichen 1995). As suggested earlier, it was not surprising the NCT has middle class roots. For these women, less disempowered and living in areas where it is the 'norm' to breastfeed, it perhaps is only to be expected that peer group supportive networks are more likely to evolve. In contrast, in areas where far fewer women breastfeed it is obviously more difficult for supportive networks to be created by women themselves. Naber and Locklin 1995) demonstrate how it is still possible. Their research in a working class area, shows how women who had successfully breast-fed themselves, were

encouraged to become breastfeeding counsellors in their own local area, liaising with the hospital and supporting women in the home.

Jenner (1988) demonstrates that a non-judgemental named supporter can enhance a woman's breastfeeding experience, but there appears to be little evidence that such support is universally available. Buckell and Thompson (1995) report that the support of the NCT was liked but was often inaccessible. Campbell et al (1995) report that information was given to women on discharge about available support in the community, but expressed concern as to the effectiveness and adequacy of the service they were offering. The inability or unwillingness on the part of health promoters to establish better inter-agency links, or to encourage women to participate more fully in providing supportive networks, demonstrates that current health promotion activity does not reflect the guide-lines proposed in the Ottawa Charter (1986).

All women require information during their pregnancy about infant feeding issues. This can be provided both at ante-natal visits and parentcraft. Empowering strategies would involve accurate information about both breast and bottle feeding presented in a non-judgemental way at a time and location convenient to the client. Weeks (1995) contests, in a journal for health promoters, that health education is the art of persuasion. An article promoting this view, and published so recently, can only serve to confuse health promoters, as it encourages, in conjunction with target setting, the health promoter to assume that the traditional health education model is still an appropriate approach to adopt.

The RCM and HVA (1995), as a response to current thinking have devised a new teaching pack aimed at enabling practitioners to develop the skills of the facilitator. The pack 'Invest in Breast Together' talks of empowering women and their partners by creating a environment of trust and partnership, with information guidance between health promoter and women. The aims of the pack are listed as follows -

- 'o To enable health visitors and midwives to become effective breastfeeding trainers.
- o To facilitate health visitors and midwives to promote their breastfeeding work to purchasers.
- o To ultimately improve the initiation and duration of breastfeeding.
- o To improve the health of the nation from the moment of birth.'

Whilst it uses the terminology found in the Ottawa Charter (1986) the interpretation does not appear to reflect the current concepts of health promotion. Empowerment of women to make an informed choice is not a central issue. Aiming to produce trainers suggests that rather than an approach of 'partnership', women still appear to be coming into a medicalised system of health promotion with the dominant professional and passive client (Naidoo and Daykin 1995), and as such, still reflects the traditional approach to health education. It is too soon to evaluate whether this is the case in practice. Nevertheless, the promotional literature not only indicates the health professional is 'in charge', it also suggests that health promoters are under a further pressure which may influence the approach they adopt. While all professionals are accountable for their actions, the need for health professionals to demonstrate the importance of their work to purchasers, may well generate feelings of insecurity. Given that achievement from the purchaser's perspective is determined by the number of women who breastfeed, as opposed to the number of women who are empowered, it is perhaps understandable that a health professional, feeling vulnerable and defensive of his/her role, will be unwilling to devolve their power to others, and will retain an authoritarian and persuasive approach.

Accessibility to information and services are also key issues as current health promotion strategies emphasise the need for equity (Whitehead 1991). It has been reported previously that the decision to breastfeed is not altered by attendance at parentcraft (Redman et al 1991). It cannot be concluded, however, that those who do not currently attend would demonstrate a similar response if they attended. While it may not increase the number of women who breastfeed, it can according to Hillier and Slade (1989) reduce anxiety, which could have a impact on the duration of

breastfeeding. They consider that there is not enough evaluation of parentcraft sessions as they do not always respond to the needs of the client. The timing and situation of the sessions are two factors, over which, the client appears to have little control. All but two of the courses run by the local clinics are during the day which may be not convenient to either the woman or support person. The hospital's parentcraft sessions are in the evening as are all those run by the NCT, but neither of these options may be accessible to those without transport. In conclusion an equitable service is not available in the local area.

For minority groups the situation appears to be more inequitable. Sharma et al (1994) reports that only 5 women attended antenatal classes out of the 93 Vietnamese women questioned in her study. With English as a second language, they were not given the services of either an interpreter or written educational material during the whole of their pregnancy. Disadvantaged by their lack of knowledge they cannot be empowered until this issue has been addressed.

Less women attend parentcraft in working class areas (White et al 1992), which is understandable given the greater constraints that impact on these women's lives, but prenatal education can still have an important influence on breastfeeding practice (Kristin et al 1990). Group education as opposed to individual advice has the added advantage of creating a supportive network. This suggests that community based parentcraft classes are preferable to hospital based sessions as local social links are more likely to continue after the baby is born. These findings concur with the observation of Naidoo and Deyton (1995) that facilitating community initiatives can make an impact by offering and encouraging a system of support as well as increasing knowledge, skills and self esteem. Areas that have addressed this issue are therefore responding to the principles in the Ottawa Charter (1986).



Analysis of a selection of current health promotion activity has demonstrated that, for the most part, the principle of empowerment does not underpin the strategies for health promotion. The setting of breastfeeding targets and their importance to the health professional as a means of demonstrating effectiveness encourages health promoters to consider breastfeeding is more important than empowerment. While the rhetoric used for current health promotion activity implies an approach based on the principles of Ottawa Charter (1986), in practice a more traditional approach of health education is apparent (Kelly and Charleton 1995). In Hillingdon, where women were asked how satisfied they were with the support they received, the issue of empowerment may have been addressed. That being the case it does appear that empowering strategies can influence the trends. However whether such strategies would achieve a similar result in another area is debatable, as the evidence does suggest that enabling strategies are more difficult to implement in areas of greater deprivation. This analysis has demonstrated that most health promoters are either unable or unwilling to develop the partnership-style relationship that Downie et al (1991) considers appropriate. As Green and Raeburn (1998) suggested, protective of their role, health professionals, appear unwilling to facilitate a partnership-style approach or allow the client to take control, while the health promoter in the voluntary sector may also be unwittingly adopting a coercive approach. In consequence, at local level, there is also little evidence that empowerment is a central issue in the current health promotion activity that relates to the practice of breastfeeding.

## **Conclusion and recommendations.**

This analysis has revealed that there is substantial scientific evidence that breastfeeding is beneficial. Both for the mother and baby, there is evidence to suggest that breastfeeding can provide long term protection from serious disease, while breast milk provides all of the baby's nutritional needs. While this evidence has accumulated and strengthened, paradoxically there is a decline in the number of babies who are breast-fed, while those babies who do receive breast milk are usually fed for less than the recommended 4 months. Research has indicated that breastfeeding is not a random activity. Women who do breastfeed in western society are most likely to be members of social classes 1&2, older first time mothers, educated until they are 19 and usually in supportive relationships. The trend over the past 100 years, with the exception of the 1970s, has been one of gradual decline; with a corresponding decline now being witnessed in the Third World. Analysis has revealed that these trends have occurred partly as a consequence of industrialisation with its accompanying reliance on science and technology. Social factors, such as the restrictions of work and level of family support, in conjunction with the availability of infant formula have reduced the number of babies who are breast-fed. The medical profession has also been influential. Telling women 'breast is best', has frequently led to inconsistent and inaccurate advice, lessening the chance of breastfeeding being successful. Furthermore the health profession's association with infant formula, by providing milk in both hospitals and clinics, has given bottle feeding credibility. Breastfeeding, in consequence, is competing in a world which increasingly considers bottle feeding the 'norm'. Women probably feel they 'choose' how they feed their baby, but evidence suggests that the forces of society are strongly affecting their 'choice'.

Influencing these trends requires a full understanding of these factors. Analysis reveals that the concept of health promotion, as reflected in the Ottawa Charter (1986), mirrors a similar understanding of the influences that impact on the practice of

breastfeeding, offering a framework for implementing health promotion activity underpinned by the principles of empowerment and equity. Oppression is identified as the 'key factor' that influences health behaviour. Inequality in society, due to class and gender, determines that those who are most oppressed are less likely to adopt a healthier lifestyle. As the analysis revealed it is women in the lower social classes who are less likely to breastfeed while many women are primarily influenced by their partners when 'deciding' whether to breast or bottle feed. The paternalistic approach of medical care and the powerful influences of the milk manufacturers also serve to illustrate that the current trends have occurred as a result of the uneven distribution of power within society. Empowerment is therefore acknowledged as the 'key principle' which should underpin all health promotion activity. The Ottawa Charter (1986) therefore proposes that healthy public policy would create a supportive, empowering environment, enabling the healthier choice to be the easy choice (Milio 1986), while, at local level, strengthening community action and developing personal skills are considered appropriate strategies. Social policy to lessen the constraints that influence breastfeeding is seen as crucial, while the health promoter has to adopt a fundamentally different role. With clients determining the agenda, the relationship between health promoter and client is one of partnership, with women able to make an 'informed choice' about health issues.

Analysis has demonstrated the complexity of the concept of 'empowerment'. Clearly the fact that empowerment is interpreted in a variety of ways by different people is a problem for the health promoter. The woman who wishes to breastfeed in public would feel empowered by doing so, but for the woman who uses an infant formula, being able to bottle-feed without feeling guilty that she is 'failing' as a mother (Oakley 1994) would be similarly empowering. Therefore while the socialist feminist framework has a similar understanding of empowerment to that of health promotion, so complex is empowerment to infant feeding, there is a 'lack of a single consistent feminist position on the controversy' (Van Esternik p68). Furthermore the ability for

empowerment to be achieved for one group at the expense of other group (Rissel 1995) makes implementation of appropriate action very difficult.

Enabling women to choose, as the evidence has shown, does not mean that they will necessarily decide to breastfeed, yet the WHO appears to have made this assumption by expecting the number of women who breastfeed to increase to 75%. While targets can provide both an incentive and reflect achievement they can only be useful if they are targeted accurately. With empowerment as the key principle of health promotion and not necessarily achieved by breastfeeding they are therefore unhelpful both for the client and the health promoter. As the WHO is using targets as part of its strategy to identify hospitals which demonstrate 'good practice' by awarding the hospital 'Baby Friendly Status' they infer that increasing the number of women who breastfeed is the principle goal. Given an empowering approach will not necessarily guarantee the target is achieved, adopting an approach which will satisfy the health promoter's employer or organisation may well seem more expedient, particularly at a time when the effectiveness of health care has never been more closely scrutinized. As such a coercive rather than empowering approach may be implemented, which may further disempower the client.

Analysis of a selection of current research material which investigates health promotion and breastfeeding has revealed that trends can be influenced by health promotion activity. Through social policy Norway and Sweden have created a more supportive environment for breastfeeding, though the extent to which women have been empowered as a consequence is less clear. Particularly in Norway, the women who bottle feed may well feel disempowered, and further research would be needed to determine the number of women who feel empowered by the experience of breastfeeding. In the UK there appears to be little evidence that health is seen as a central issue of policy making. Healthy public policy to create a more supportive environment is either ignored or conceptualised inappropriately. The milk

manufacturers are more concerned with expanding their market (Robins1993), and the Government, ideologically opposed to the philosophy that underpins the current concept of health promotion, still considers health behaviour to be the individual's responsibility (Benezeval and Judge 1990). Particularly at this level, the fact that the validity of the current concept of health promotion is contested, and/or interpreted differently, must limit its potential to influence trends.

At community level there is little evidence that health promoters are working in the fundamentally different way advocated in the Ottawa Charter (1986). Health promoters can and do use the rhetoric of the current concept without applying the underpinning principles. A client centred approach, community participation and partnership are spoken of, but either ignored or misinterpreted. Predominantly, practice reflects the traditional health education approach, which is ineffective because it does not recognise the real influences that impact on breastfeeding behaviour and is further disempowering, in that it brings women into contact with a medical system of dominant professional and passive client (Naidoo and Daykin 1995).

Empowerment is however possible in practice and it does appear that it can influence the trends. The research in Hillingdon (Bucknell and Thompson 1995) which demonstrated a 4% rise in the number of breastfeeding women over a 3 year period, also revealed that these women were satisfied with the service they received. This raises two points. Firstly, it is difficult to say whether client satisfaction is the most reliable indicator of empowerment, but it is necessary that empowerment is measured as it can only be the true indicator of the effectiveness of health promotion activity. Secondly, the potential to effect a similar change in another area cannot be assumed. Given that social circumstances are so influential to breastfeeding practice and evidence that enablement is more difficult in the areas of greatest deprivation, it is likely that similar strategies implemented elsewhere may be less successful. Were this 4% increase to be replicated throughout the country it would only redress the 4%

decline that has occurred since 1980 (White et al 1992), which Whitehead (cited in Townsend and Davidson 1988) would probably consider was as a result of the increasing disparity between the social classes over the previous decade. Therefore without a more supportive environment, which seems unlikely given the current political climate, it appears unlikely there will be a significant increase in the number of women who breastfeed, even if the health promotion carried out at community level is empowering in its execution and effect.

The current inability to effect a significant change in the practice of breastfeeding has implications for future practice. A better understanding of empowerment, and relevant health promotion strategies are needed. All women need to be empowered including those who bottle feed. Breastfeeding perhaps needs to be viewed within the context of infant feeding. Health promotion activity can then respond to the needs of all women who have to make decisions about infant feeding methods. The current inability to measure health promotion activity through empowerment is a distinct disadvantage (Rissel 1995). The research in Fife (Campbell et al 1995) would have been more meaningful if empowerment had been measured as well. With accountability for health promotion activity demonstrated by evidence of empowerment, health promoters may be further encouraged to implement appropriate strategies. While monitoring infant feeding patterns would demonstrate the influence of health promotion on the patterns of breastfeeding and bottle feeding.

This has implications for the WHO, as clearly the lack of understanding and the difficulty in measuring empowerment are barriers which need to be overcome. As the 'mouthpiece' for health promotion the WHO might ensure that the codes of practice are written in a way that demonstrate a commitment to empowerment. It could consider initiating further debate on the concept of empowerment, to ensure that current theory is better understood. The current target setting approach needs to be reviewed. Targets can be an effective way of encouraging people to work, but

measuring/targeting the effectiveness of health promotion activity through empowerment, would be more appropriate. Meanwhile reporting health promotion activity at international, national and local level that demonstrates empowering practice might encourage others to work in similar ways.

Given that the current British Government rejects the materialist/structuralist explanation that links deprivation with unhealthy behaviour (Black Report 1980), it is likely that any recommendations would be ignored. It appears equally unlikely, given the previous evidence, that infant food manufacturers will willingly alter their approach. It is therefore important that the WHO continues to communicate with both parties to encourage a change in attitude. The 'pro-breastfeeding' public need to state their case, although care must be taken not to disempower other women when demands for change are requested. Work-place nurseries would be a way of further empowering those women who wish to work and breastfeed, while advertising, in relation to infant feeding, needs to be monitored to ensure it is accurate and unbiased. However, while breastfeeding in public may be empowering for some women, for those who live in the poorer areas feeding in public may be distasteful. In this case facilitating breastfeeding in private, with baby feeding rooms in public places, may be more appropriate (Ineichen 1995). Only by asking women, will it be possible for the 'pro-breast feeding lobby' to campaign for action that will empower all women.

The lack of a more supportive environment should not deter health promoters from promoting community action and developing personal skills. Creating an appropriate climate for health promoters to practise appropriate strategies has implications for health care managers. Monitoring local patterns of infant feeding would be more appropriate, while locally based research would both enable health promotion to respond to client need and evaluate client satisfaction (Evans 1995), thus encouraging health promoters to adopt a more empowering approach.

Clearly health promoters need to have a good understanding of the principles of empowerment and equity. They need the skills of facilitator, advocate and supporter. They also need to be able to identify their clients' needs and evaluate client satisfaction. Research is intrinsic to their new role. For the health promoter, working in either a statutory or voluntary capacity, this has implications for the initial training and later update of professional practice, with co-operation needed between health promoters, employers and local educational establishments, concerned with the training of health promotion, to ensure that appropriate learning materials are available.

The analysis has revealed that appropriate strategies would involve making all health promotion client centred. The team midwifery approach adopted in Hillingdon is to be recommended. Empowerment involves asking women what they would like to discuss at parentcraft classes (Redman et al 1991), when and where parentcraft would be most convenient and welcoming the woman's personal supporter, as well as identifying the possible need for creche facilities, or translators where English is a second language. Creating the support networks that women are asking for could be facilitated by encouraging lay breastfeeding counsellors from local areas to liaise between hospital and the community (Locklin and Naber 1993). Strengthening the links between hospital, community and voluntary agencies would allow practice to be better evaluated and new health promotion initiatives to be developed. Working in partnership would increase the likelihood that information given to clients would be consistent. As such at local level, the health promoter, with a better understanding of empowerment, by working in close co-operation with other relevant agencies and operating a client centred, non-judgemental approach, would implement the concept of health promotion reflected in the Ottawa Charter (1986) in an empowering way.



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